University of Alberta

School Counsellors' Experiences of Client Suicide

by

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Abstract

The purpose of this study was to explore professional school counsellors' experiences of client suicide. Aside from the family, the school has the most contact with children and adolescents during their formative period. Because school counsellors are in a unique position to work with suicidal clients and are faced with the aftermath of client suicide, school counsellors' experiences warrant further study.

This study was conducted with seven school counsellors who were recruited through listserve emails, newsletters, personal contacts and a website. The participating school counsellors practiced in a mix of rural and urban settings across four provinces, had lost a counselling client to suicide, received training in the area of educational psychology or a counselling related field and possessed the desire to reflect on their experiences.

A basic interpretive qualitative study was the framework guiding the exploration of this research. Data were collected primarily through a series of in-depth interviews and through a research journal that was kept to document relevant information and evolving interpretations. Thematic analysis was used to present the data so interview transcripts were coded and then analyzed until four themes were identified: *Taming the Control Beast*; *Wearing the Mask; Interpreting the Dance;* and *Staying in the Game*. Taming the Control Beast explores the lack of control participants had over their clients' suicides and their subsequent attempts to control how their clients' deaths were processed. Wearing the Mask focuses on how counsellors processed their personal experiences within their work settings. The theme Interpreting the Dance underscores the importance of processing the personal and emotional experience of client suicide while Staying in the Game presents the strategies and support participants utilized so they could continue counselling in the school system.

With the rise in youth suicide, consistency through national standards for training and practice are needed so that school counsellors can become better prepared to handle the aftermath of client suicide. Further, resources for school counsellors are needed because preparation and support can provide a buffer against secondary traumatic stress and burnout. Resources such as professional, peer, and personal support as well as debriefing and self-care were identified as important elements in the healing process for counsellors who have lost clients to suicide.

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Dedication

I dedicate this dissertation to Bob, Fred, James, John, Anne, Emily, and Maggie. I am changed because you invited me into your lives. Thank you.

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CHAPTER ONE

INTRODUCTION

The purpose of this study was to explore professional school counsellors' experiences of losing clients to suicide. As a former school counsellor who has worked with many suicidal youth, I have a close interest in this topic. As a practitioner, I continually struggle to find some sense of security in my work with adolescents. When struggling professionally with particular issues, I often turn to the literature for support. While it is of concern that there is only limited research on psychiatrists, psychologists, nurses, and psychotherapists' experiences of client suicide, it is of more concern that the experiences of school counsellors have been neglected in the research literature. School counsellors face child and adolescent suicide as frequently as any other group of mental health professionals (Borders, 2002; Lockhart & Keys, 1998; Schmidt, 2003). Therefore, school counsellors' experiences need to be researched. In the introductory chapter, researcher subjectivity is addressed, the need for the study is articulated, and the purpose of the study is identified.

Researcher Interest

In many ways the root of my interest in this topic is connected to my own childhood and adolescence. I considered myself fortunate during my childhood because I always had good friends and a supportive family to help me navigate my way. However, I knew that many of my peers were not cushioned by a similar support system. Even during my youth I was struck by how easy it was to become mired in the process of growing up. It seemed like adolescence was a road traveled by children carrying adult weight. What made it even worse was listening to adults who had survived the experience suggest that childhood and adolescence are the best years of one's life. For some of my peers, and for a number of children and adolescents now, I imagine hearing that sentiment is depressing at best.

I have remained keenly interested in the experiences of children and adolescents throughout my professional life. For many young people, childhood and adolescence are the times when much of their adult frame of reference is formed. Friendships are established and dissolved, important decisions are made, relationships begin and end—all for the first time. As a teacher, and later as a school counsellor, I found myself amazed by the grace many adolescents demonstrated as they embarked on the often painful journey of self-discovery. The majority of my time, though, was spent working with students who struggled to simply survive.

One of the memories I carry with me of my first year as a school counsellor is of a grade nine girl who came into my office dehydrated from what was clearly a weeping fit. Judging from the swelling and blotchiness of her face, the tears had been flowing for quite some time. I braced myself to hear about a situation of abuse, a death in the family, certainly something extraordinary. Once she was composed enough to speak, with her whole body involved in each sob, she recounted the details of a phone call she received the previous night which culminated in her getting dumped by her boyfriend. After some prompting and reassurance that she would most likely find love again, the client revealed to me that she and her boyfriend had been dating for almost a whole week. I have kept this memory with me because it taught me a valuable lesson about adolescents. The initial temptation from an adult perspective might have been to laugh, tell her how much worse it can get, or minimize the experience in some way. However, the student sitting in a crumpled heap in my office was in raw, palpable pain. She had just experienced her first break up. This experience, which started the previous night and lasted for several more days, was the prototype, her first frame of reference, for relationship rejection.

Having worked with a number of suicidal adolescents, I also carry with me many memories of driving home after particularly difficult sessions with suicidal clients and hoping and praying that they would stay safe until we met the next day. As an adult, with multiple frames of reference for loss, anger, and sorrow, I could always see the way out of the client's experienced darkness. However, it takes time to help young people see other options when they feel so trapped. All that I could do was hope that the support systems and coping strategies we put in place would protect my clients from themselves. I was also cognizant that my clinical judgment of clients' levels of suicidality could be turned on a dime if they happened to get in a fight with a member of their family that night, decided to go out partying with friends and allowed alcohol or drugs to impair their sense of reason, or received a disturbing phone call from a friend. All of these factors combined were responsible for a number of tense drives home from work and a few lasting gray hairs.

Need for the Study

Sigmund Freud, the founder of modern psychotherapy, was the first to investigate how analysts experienced the therapeutic relationship and what impact clients' issues had on their analysts (Stroebe & Schut 2001; Stroebe 2002). This type of research continues to be important and, in particular, counsellors' experiences of client suicide merits further study (Brown, 1989; Chemtob, Hamada, Bauer, & Pelowski, 1989; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988; Gitlin, 1999; Hendin, Lipschiz, Maltsberger, Haas & Wynecoop, 2000; Menninger, 1991; McAdams & Foster, 2000; Richards, 2000; Valente, 1994, 2003) as in all Western countries, suicide ranks among the top ten causes of death (Menninger, 1991; Provini, Everett & Pfeffer, 2000; Rosenberg, 1999; Shneidman, 2001; van der Wal, 1989; van Hooff, 2000). For children and adolescents, the ranking rises significantly (Beautrais, Joyce, & Mulder, 1996; Pirkis et al., 2003; Rosenberg, 1999).

Limited research has been conducted on the impact of client suicide on psychiatrists, psychologists, nurses, and psychotherapists. The consensus among researchers in this area is that the existing literature is not comprehensive (Fox & Cooper, 1998; Gitlin, 1999; Hendin, Haas, Maltsberger, Szanto, Rabinowicz, 2004; McAdams & Foster, 2000; Menninger, 1991; Richards, 2000; Valente, 1994, 2003). For professionals who routinely encounter the "occupational hazard" of client suicide (Chemtob et. al, 1989, p. 419), counsellors remain poorly trained and ill prepared for the aftermath of such an event (Dexter-Mazza, & Freeman, 2003; McAdams & Foster, 2000; Rosenberg, 1999; Valente, 1994).

McAdams and Foster (2000) reported that information about the impact of client suicide on counsellors, either professionally or personally, is simply not available. The few studies that have been conducted on the frequency and impact of client suicides have focused almost exclusively on student and professional psychiatrists and psychologists (Chemtob et al., 1988; Chemtob et al., 1989; Dexter-Mazza & Freeman, 2003; Fox & Cooper, 1998; McAdams & Foster, 2002; Valente, 2003). Although there are similarities with other mental health professionals, school counselling is a unique discipline as "school counselors are frontline mental health professionals for students and families who present the gamut from normal developmental issues to serious dysfunctional problems" (Borders, 2002, p. 184). Despite the vast number of books and articles dealing with the various aspects of suicide risk, interventions, and postventions, few address the needs of counsellors after their clients commit suicide (Barr, 1996; McAdams & Foster, 2002; Valente, 2003).

Statement of Purpose

Child and adolescent suicide rates in Canada have increased in recent years (Statistics Canada, 2003) and are fast becoming a societal issue that needs to be addressed in the research literature. Further, the societal view of who is considered a survivor of suicide has expanded beyond what was once limited to family and friends (Jordan, 2001; Knieper, 1999) and now includes mental health professionals (Berman, Jobes, & Silverman, 2006; Farberow, 2005). Child and adolescent suicide has both a personal and professional impact on the mental health professionals who work alongside these youth in an attempt to help them find meaning in their lives and alternative solutions to their problems. School counsellors are one of the professional groups who work closely with these at-risk children and adolescents (Allen, Burt, Bryan, Carter, Orsi, & Durkan, 2002; Coder & Nelson, 1991; King, Price, Telljohann, & Wahl, 1999; Lockhart & Keys, 1998; Schmidt, 2003). To my knowledge, though, there are no studies that explore the experiences of school counsellors who have lost clients to suicide.

This study focuses exclusively on professional school counsellors who have lost clients to suicide. For the purpose of this study the term *professional school counsellor* is used to refer to school counsellors who have training in counselling or educational psychology. As a result of the training and credentials they have, these school counsellors provide services to their clients that are comparable with outside community agencies (Barwick, 2000; Lockhart & Keys, 1998). In some school districts teachers with no counselling training are hired to fill school counselling positions. In this study what distinguishes professional school counsellors from other professionals in the field, such as teachers, who have the title of school counsellor is their training in counselling or a related field.

The purpose of this study was to explore the experiences of client suicide for the school counsellors who participated in this research. In order to develop an understanding of the experience of client suicide, a basic interpretive qualitative study was used to elicit school counsellors' experiences of client suicide and the impact of those experiences. The data were gathered through in-depth interviews that provided the opportunity for participants to relate their unique experiences of the phenomenon. The research questions that framed the interviews were: "What are school counsellors' experiences of client suicide?" and "What impact did the participants feel client suicide had on their lives?"

CHAPTER TWO

LITERATURE REVIEW

The following review examines the relevant literature in the area of school counsellors' experiences of client suicide. In order to provide a comprehensive review, the literature has been divided into seven categories: definition of terms, perspectives on suicide, child and adolescent suicide, school counselling, impact of suicide on mental health professionals, bereavement, and burnout.

Definition of Terms

In this document, *counselling* and *psychotherapy* will be used to describe "the process of establishing a relationship to identify people's needs, design[ing] strategies and services to satisfy these needs, and actively assist[ing] in carrying out plans to help people make decisions, solve problems, develop self-awareness and lead healthier lives" (Schmidt, 2003, p. 2). The generic terms *mental health professionals* and *clinicians* will be used to refer to those trained in mental health with a command of the general theory and knowledge in the fields of psychology and human development. Specialties are often developed within the professional settings in which these mental health professionals work or through the receipt of additional training (Baker & Gerler, 2004; Schmidt, 2003).

Perspectives on Suicide

Suicide is solely a human act. Humans are the only identified species known to willfully take their own lives (Shneidman, 2001; van Hooff, 2000). Further, humans have the unique ability to form opinions about suicide, which have been clearly articulated throughout history (van Hooff, 2000). Across time and continents alike, people have experienced passionate responses, both positive and negative, toward the act and the performers of suicide. These responses have been largely influenced by the societal doctrines, norms and time-bound contexts (Cvinar, 2005; Maris, Berman, & Silverman, 2000). Thus, perspectives on suicide have been affected by the changing societal context. The Christian church, for instance, has played a leading role in how suicide is viewed (Shneidman, 1999; van Hooff, 2000). Shame and stigma first introduced with the advent of Christianity continues today (Cvinar, 2005; Domino & Leenaars, 1995; Lester, 1998).

Child and Adolescent Suicide

In all Western countries, suicide ranks somewhere between the fifth and tenth most common cause of death (Berman, et al., 2006; Menninger, 1991; Provini et al., 2000; Shneidman, 2001; van Hooff, 2000). The statistics for child and adolescent suicide rank it between the second and third leading cause of death (Miller & Taylor, 2005; Pirkis et al., 2003; Statistics Canada, 2003; US Department of Health & Human Services [USDHHS], 2004). When adolescents look at their reflections in the mirror, they see one of the greatest dangers they will face during their youth. Youth between the ages of 15 and 19 are more likely to commit suicide than to die from disease (Berman et al., 2006; Pirkis et al., 2003; USDHHS, 2004). As cited in Powell Stanard (2000), the Center for Disease Control reported that suicide rates increased between 1980 and 1997 by 109% for adolescents aged 10 to 14. Statistics Canada reported in their 2003 census that while only 1.3 per 100,000 suicides were committed by children between the ages of 1 and 14, there was an increase to 10.2 per 100,000 completed suicides of adolescents aged 15 to 19.

As suicide completion rates rise, a heightened need emerges for mental health professionals to uncover the experiences of these suicidal youth and to be prepared for the aftermath of child and adolescent suicide (Allen et al., 2002; King, 1999; Lockhart & Keys, 1998; Maples, Packman, Abney, Daugherty, Casey & Pirtle, 2005). In a recent study, Pirkis et al. (2003) found that adolescents between the ages of 13 and 17 were more likely to seek and receive services than their 18 year and older counterparts because they "had greater access to school-based counseling services" (p. 391). Most people who commit suicide have recently seen a primary care practitioner (Pirkis et al., 2003; Valente, 2003). School counsellors are often primary care practitioners as they are the most easily accessed mental health professional for school-aged children (Gladding, 2004; Lockhart & Keys, 1998).

Clinicians working with suicidal children and adolescents require different skill-sets than clinicians working with adult populations (Erford, 2003). Risk factors for child and adolescent suicide include physical, personal, and family issues as well as lack of identity development (Jurich & Collins, 1996; Portes et al., 2001). Adolescents enter into the precarious task of breaking away from previously established adult support systems at the time when many are at risk for suicide. Peer factors, which consist of acceptance into peer groups, involvement with delinquency, and drug and alcohol use are also influential during this time (Jurich & Collins, 1996).

As there are developmental and cultural factors involved, clinicians working with suicidal youth also need to be aware of the diversity within this population (Pfeffer, 2003). For example, adolescence is a time of psychological and physiological change. Adolescent suicide can be impulsive and completed during a time of crisis (Pfeffer, 2000). However, adolescents can also experience chronic suicidal ideation where warning signs often precede the suicide (Portes et al., 2002; Sink, 2005). If heeded, those warning signs can lead to adolescents receiving appropriate counselling services (Lambie & Williamson, 2004). Thus, school counsellors who are on the front lines working with this at-risk population must be highly attuned to the warning signs, risk factors, interventions, and postventions for adolescent suicide (Gladding, 2004; King et al, 1999; Laux, 2002; Schmidt, 2003; Stefanowski-Harding, 1990).

School Counselling

Development of School Counselling

The counselling and guidance movement emerged in Canada near the turn of the twentieth century (Baker & Gerler, 2004; Jewel, 2005; Robertson & Paterson, 1983). The philosophical underpinnings of this movement grew out of the Industrial Revolution and aimed to facilitate the personal worth and growth of children and adolescents while educating them about occupational opportunities (Baker et al., 2004; Gladding, 2004). While an educational and occupational emphasis was established during the early 1900s, the emphasis shifted in the 1960s. Individual psychotherapy with students increased with the establishment of the Rogerian approach (Baker & Gerler, 2004; Lambie & Williamson, 2004).

School Counsellor Training

Despite the daunting position school counsellors assume, until the late 1980s "apart from the requirement that school counselors must hold a teaching certificate, there [we]re no formally recognized requirements for certification as a counselor in most parts of Canada" (Robertson & Paterson 1983, p. 491). That has changed to some extent in recent years as some school boards now state that a school counsellor should hold a professional teaching certificate and have a recognized Master's degree in counselling psychology or a related field (Paterson & Janzen, 1993; British Columbia School Counsellors' Association [BCSCA], 2002). What typically distinguishes teachers functioning as school counsellors from professional school counsellors is the level of specialized training they have received. School counsellors are expected to be knowledgeable in the areas of human growth and development, social and cultural foundations, the helping relationship, group work, career and lifestyle development, and professional orientation (Perusse, Goodnough & Noel, 2001; Sink, 2005).

Professional School Counsellors' Mandate

Unfortunately, the role of the school counsellor has not been well delineated (Kendrick & Chandler, 1994; Schmidt, 2003; Sink, 2005). In the United States, with a strong national organization in place (American School Counseling Association [ASCA]), an attempt for role definition has resulted in an identity debate (Gysbers, 2004; Lambie & Williamson, 2004).

Gysbers (2004) framed the debate as a question of whether school counsellors view themselves as mental health practitioners or educators with expertise in counselling. In Canada, that process of role clarification has not begun. While the Canadian Counselling Association (CCA) has a School Counselling Chapter, the CCA does not regulate school counselling practice. The difficulty in role definition is also due to the inconsistency between districts in determining the nature of school counselling services. Typically school counsellors are employed by their local school boards (Paterson & Janzen, 1993) and each school board develops their own counselling policy. At present, school counsellors' mandates are extensive, tailored to meet the needs of each school board; if school counsellors are to have a unified professional identity, role clarification will be required.

The general aim of school counselling services is to support "student success in the areas of academic, career, and personal-social development" (Erford, 2003, p. 8). This is achieved through counselling, consultation, and co-ordination (Fitch, Newby, Ballestero, and Marshall, 2001; Perusse et al., 2001; Ponec & Brock, 2000; Schmidt, 2003; Sink, 2005). School counsellors provide individual, drop-in, small group, and large group counselling. Consultation is typically school-based, whereas coordination extends the liaison to community agencies and services (Baker & Gerler, 2004; Jewell, 2005; Schmidt, 2003).

School Counsellors as Mental Health Professionals

The role of the school counsellor has changed in recent years (Atkinson & Hornby, 2000; Ballard & Murgatroyd, 1999; Lockhart & Keys, 1998; Sink, 2005). Mental health concerns among school-aged children have increased. Suicide, accidental or natural death, and violence are a current school counselling reality (Jewell, 2005; Lockhart & Keys, 1998; Peach & Reddick, 1991). Pirkis et al. (2003) used data from a national longitudinal study of adolescent health with a sample size of 15,483 adolescents to study the patterns of suicidal adolescents in their receipt of psychological services in the United States. According to Pirkis et al., "A recent review of school-based mental health and social services suggested that counseling is primarily provided by school counselors, school psychologists, and school social workers. Seventy-seven percent of schools have access to a school counselor" (p. 392). Schools are microcosms of society (Schmidt, 2003), so in times of restraint and budgetary cutbacks, "serious mental health problems fall to school counselors" (Lockhart & Keys, 1998, p. 4) because there are not enough available community resources (Atkinson & Hornby 2000; Lockhart & Keys, 1998).

While school counsellors previously focused on guidance, their role has expanded to include personal counselling (Barwick, 2000; Sink, 2005). School counsellors now encounter the same issues faced by counsellors in other settings: "bullying, bereavement, family divisions, substance abuse, physical, sexual and emotional abuse, sexual and racial harassment, unwanted pregnancy, isolation" (Barwick, 2000, p. 1). School counsellors are professional counsellors who work in school settings, which means that the primary difference is setting not professional skill set (Kendrick & Chandler, 1994; Lambie & Williamson, 2004). Therefore, "current conditions suggest that the time is ripe for school counselors to redefine themselves as school 'mental health' counselors and to take a proactive stance in stimulating the changes necessary within their school systems to support this new role" (Lockhart & Keys, 1998, p. 2). As the needs of the student population and society have changed, so too have the training requirements and role definition of professional school counsellors (Allen et al., 2002; Ballard & Murgatroyd, 1999; Lambie & Williamson, 2004).

Challenges for the School Counsellor

School counsellors have relatively little "control over their day-to-day work activities" (Paisley & Borders, 1995, p. 150) as counselling services are funded at the school board level and determined by administrators (Paisley & Borders, 1995; Paterson & Janzen, 1993; Ponec & Brock, 2000). As school counsellors are accountable to their principals, many school counsellors assume responsibilities that are only peripherally connected to their training and professional role (Fitch et al., 2001). School counsellors face a number of challenges in the workplace. These challenges include:

1. The school counsellor's need to please individuals in positions of power and influence for reasons of self-interest;
2. The school counsellor's theoretical-philosophical orientation;
3. The expectations and demands of faculty and colleagues;
4. The wants and needs of the student; and
5. The demands of parents and others outside the school system. (Tyson, 2000, p. ix)

As the educational system continues to be hit with budgetary cutbacks, school counsellors are in the precarious position of defending their school counselling roles while striving to meet the expectations of multiple stakeholders (Ballard & Murgatroyd 1999; Lambie & Williamson, 2004; Lockhart & Keys, 1998).

School Counselling as a Unique Discipline

School counselling is different from other counselling and psychotherapy disciplines in several ways. School counsellors' schedules are not fixed—they do not always see clients at appointed times for an hour of therapy (Baker & Gerler 2004; Schmidt, 2003). Most clients appear spontaneously at school counsellors' doors in some state of crisis or confusion. Further, as they have a large number of clients to serve, "school counselors engage in a greater variety of counselling interventions, many of which are very brief" (Baker & Gerler, 2004, p. 125-126). School counsellors are also unique because they have a dual mandate. Mental health issues typically interfere with students' ability to learn. Therefore, the role of the school counsellor is to help these students resolve their crises and cope with their challenging experiences, which in turn helps students be more successful in school (Barwick, 2000).

Aside from the family, the school has the most contact with children during their formative years (Heller, 2000; Sofronoff, 2005). This places the school counsellor in a unique position to address the mental health needs of students (Tyson, 2000). Adams (2000) detailed the uniqueness of the school counselling role:

> My observations of them [students] in the classroom and playground, not normally accessible to the therapist, give me a broader sense of their difficulties, and an understanding which I am able to hold in mind within therapy. Equally, the insights I gain by seeing a child in therapy provide me with clues about what might be going on in the classroom and the impact it might be having on the learning task. (p. 94)

As school counsellors have access to their clients in context, they are able to design appropriate interventions (Adams, 2000; Barwick, 2000).

Impact of Suicide on School Counsellors

School counsellors are on the front line because they interact with children and adolescents daily (Borders, 2002; Lockhart & Keys, 1998). Moreover, school counsellors are often the ones involved in working with the families of children and adolescents who have attempted or completed suicide because "families who fear the word psychology often trust the school counselor to explain the phenomenon of suicide" (Stefanowski-Harding, 1990, p. 334). Stefanowski-Harding (1990) reviewed literature on the implications of child suicide for the school counsellor. She stated: "Often at the center of the storm is the school counselor, expected to soothe, explain, heal, and cope with the aftermath" (p. 328). Inevitably some school counsellors will experience the loss of a client to suicide as they work so intimately with this at-risk population (Allen et al., 2002; Stefanowski-Harding, 1990). Despite the significant role school counsellors play in dealing with adolescent suicide, research has not been conducted on the experiences of school counsellors who have lost clients to suicide.

School counsellors are among the subset of mental health professionals most affected by the epidemic of child and adolescent suicide (King et al., 1999; Pirkis et al., 2003). In fact, school counselling is one of the only counselling services not impacted by the typical barriers of cost and stigma that usually hinder adolescents' ability to receive services (Pirkis et al., 2003). In a study conducted by Kendrick et al. (1994), they found that 93% of the school counsellors sampled had worked with students expressing suicidal ideation. Yet, school counsellors receive little to no preparation in their training programs for dealing with the aftermath of suicide (Allen et al., 2002; Jewell, 2005; Valente, 1993).

Impact of Suicide on Mental Health Professionals

Despite the reality that client suicidality is a crisis mental heath professionals face, very few feel adequately prepared to deal with the aftermath of suicide (Allen et al., 2002; Fox & Cooper, 1998; McAdams & Foster, 2002). The impact of suicide on clinicians can be far-reaching and long lasting (Foster & McAdams, 1999; Grad & Michel, 2005; Hendin, Lipschitz, Maltsberger, Haas, and Wynecoop, 2000; Maltsberger, 1992; McAdams & Foster, 2000; Menninger, 1991; Rycroft, 2005). Menninger (1991) interviewed 88 practicing psychotherapists and found that 40% of the psychotherapists he interviewed stated that they had lost a client to suicide. Of the psychotherapists who had lost a client to suicide, 66% said that the loss changed the way they practiced psychotherapy. Hendin et al. (2004) studied 34 therapists levels of distress after patient suicide and found that over one-third of the participants experienced severe distress. Thus, the loss of a client to suicide can have a significant impact on mental health professionals personally and on how they practice professionally.

While suicide cannot be predicted, the frequency of client suicide is influenced by several factors (Chemtob et al., 1988; Chemtob et al., 1989; McAdams & Foster, 2000; Richards, 2000). Mental health professionals working with mentally ill populations, high-risk populations, and in clinical or hospital settings tend to experience more client suicides than professionals practicing in other milieus (McAdams & Foster, 2000; Valente, 2003). Further, Chemtob et al.(1988) found that client suicides correlate to the psychologists' levels of training. Those with more training tend to work in higher-risk settings and consequently experience more client suicides. Students in training tend to work under experienced supervisors who work with more challenging clients (Dexter-Mazza &Freeman, 2003; Valente, 2003). Thus, psychology students and psychiatric residents seem to experience higher proportions of client suicides not because they have poorly developed skill-sets but because of the type of clients they are assigned (Chemtob et al. 1988; Dexter-Mazza & Freeman, 2003; Valente, 2003).

Regardless of how well trained clinicians may be or the setting they practice in, losing clients to suicide is difficult (Grad & Michel, 2005; Menninger, 1991). Client suicide often leaves mental health professionals to "agonize over the details, circumstances, and meaning of the suicide, and examine their personal responsibility for preventing the suicide" (Valente, 2003, p. 19). McAdams & Foster (2000) stated that even 18 months after a counsellor's experience of client suicide there was only a "modest reduction from the debilitating counselor stress levels that were evident in the week immediately after the event" (p. 239). It can be inferred from the statistics on suicide that client suicide is an "occupational hazard" for those in the mental health profession (Chemtob et al., 1988, p. 419); however, that occupational hazard impacts not only clinicians' professional lives, but their personal lives as well (Hendin et al., 2004; McAdams & Foster, 2000; Miriyam Weiner, 2005; Rycroft, 2005; Valente, 2003). Thus, a gap exists between viewing client suicide as an occupational hazard and recognizing the personal impact of client suicide on clinicians.

Mental Health Professionals' Reactions

Mental health professionals' reactions to the suicide of their clients contain both emotional and cognitive features (Hendin et al., 2000, 2004; McAdams & Foster, 2000). McAdams and Foster (2000) outlined some of these features in a study they conducted on the impact client suicide had on counsellors. They found that 24% of the counsellors initially sampled experienced the loss of a client to suicide and "as with their counterparts in psychology and psychiatry, counselors reported feeling anger, guilt, and a loss of self-esteem. However, they [counsellors] also reported having intrusive and avoidant thoughts about the crisis that were higher than those of psychologists or psychiatrists" (p. 118). McAdams and Foster inferred from their findings that the intensity of counsellors' reactions positively correlated with the strength and nature of the therapeutic relationship. In fact, some researchers have found that clinicians demonstrate emotional reactions to client suicide at a magnitude similar to that of the family members of the deceased (Hendin et al., 2004; James, 2005; Richards, 2000).

Mental health professionals respond to their loss in unique ways; however, those responses generally fall within certain parameters (Gitlin, 1999; Hendin et al., 2000). Some respond by limiting the number of suicidal clients they see or decline referrals of suicidal clients (Berman et al., 2006; Fox & Cooper, 1998; Hendin et al., 2000). Other clinicians respond by increasing their caseload in order to prove to themselves and others that they are still competent. Few mental health professionals are aware that their change in practice is a compensatory response to the death of their clients (Hendin et al., 2000). While individual responses may vary, the overarching emotional experiences reported by bereaved clinicians seem to be shock, sorrow, anger, guilt, anxiety, and self-doubt (Berman et al., 2006; Gitlin, 1999; Grad & Michel, 2005;

Hendin et al., 2000; McAdams & Foster, 2000; Menninger, 1991; Richards, 2000; Valente, 1994).

Barriers to the Healing Process

Despite the benefit of personal counselling, very few counsellors seek professional assistance in processing the loss of their clients (McAdams & Foster, 2000). This disregard for personal counselling may stem from the different standard mental health professionals hold themselves to than the standard they have for those they help. Counsellors may be reticent to seek professional services because they equate seeking help with their own failure to heal themselves (Everall & Paulson, 2004). Valente (2003) discovered through her work: "In the aftermath of suicide, therapists believe they need to control their emotions, control situations, and provide leadership, but this may be complicated by personal responses to grief. Coping with a patient's suicide may be one of the most difficult challenges for clinicians" (p. 18).

Even when consultation procedures are established within an organization, counsellors rarely make use of the service (McAdams & Foster, 2002). McAdams and Foster noted: "that openness to their support could sometimes be hampered by the counselor's own feelings of failure and professional inferiority in the presence of other professionals" (p. 235). In addition to professional resources, McAdams and Foster cited personal resources as vital to the healthy recovery of counsellors after client suicide. Friend and family support seem to be important because they are easy to access, free from judgment or evaluation, and known to clinicians on a personal level (Gitlin, 1999; McAdams & Foster, 2002; Richards, 2000).

Mental health professionals typically find that they experience both a personal and a professional reaction to the loss of their clients (Anderson, 2005; Gitlin, 1999; McAdams & Foster, 2000; Weiner, 2005). Despite the statistics indicating that client suicide is an "occupational hazard" for clinicians (Chemtob et al., 1988, p. 419), very few have established support plans to guide them through the aftermath of client suicide (Allen et al., 2002; Foster & McAdams, 1999; McAdams & Foster, 2002; Valente, 2003). Resources need to be put in place for clinicians to work through their feelings of responsibility so that their clinical judgment and practice are not compromised (Valente, 1994).

Mental health professionals complete their training feeling ill-equipped to work with suicidal clients and to handle postvention protocols after client-completed suicide (Allen et al., 2002; Dexter-Mazza & Freeman, 2003; Neimeyer, 2000). According to McAdams and Foster (2002), "it was both surprising and disturbing to also find that the preparation that [counsellors] had received through formal education was of little reported value to them during the actual experience of the suicide of a client" (p. 237). Valente (1993), too, was disturbed that "many training programs for mental health professionals, such as those for clinical psychologists, neglect the topic of suicide evaluation or prevention, and thereby ignore the potential effects of suicide on the therapist" (p. 614). Dexter-Mazza and Freeman (2003) reported in their study that 99% of their respondents indicated they had treated suicidal clients, yet only half of those respondents reported receiving formal training for working with a high-risk population. As suicide is a common, acute, and practice-altering issue faced by clinicians, it is disturbing that the topic is not covered thoroughly in training facilities.

Bereavement

The bereavement literature is vast, with historical roots dating back to Sigmund Freud and his mentor, Breuer (Shimshon-Rubin, 1996; Stroebe, 1992, 2002; Stroebe & Schut, 2001; Walsh-Burke, 2006; Worden, 2002). Since the early twentieth century, the literature has dealt primarily with two streams of thought, "on the one hand, the relationship to the deceased has been considered the cornerstone of the mourning process, and yet on the other, it is the ability to return to robust functioning, unencumbered by indices of difficulty or psychiatric systems" (Shimshon-Rubin, 1996, p. 217). With the publication of *Mourning and Melancholia*, Freud introduced grief as a research worthy construct (Stroebe, Hansson, Stroebe & Schut, 2001); his efforts paved the way for further bereavement literature (Jeffreys, 2005; Stroebe, 2002; Walsh-Burke, 2006). Researchers have taken up that interest and the bereavement literature has grown since Lindmann's 1944 study on acute bereavement experiences of a tragic nightclub fire (Valente, 2003). Lindmann's work served as the first empirical study of acute grief (Stroebe & Schut, 2001).

In order to understand the literature, a distinction between bereavement, grief, and mourning needs explicit mention. In general terms, grief represents intrapersonal experiences such as the inner thoughts and feelings one experiences after a loss. Mourning is the interpersonal behaviors and rituals that are observable to others. Bereavement refers to the cultural and social role one assumes after experiencing a death (Jeffreys, 2005).

Bereavement Theories

Bereavement experiences are unique. Therefore, the bereavement literature discusses the process as circular and fluid as there is not a specific progressive model for processing grief (Berman et al., 2006, Freeman, 2005; Jeffreys, 2005). Despite the individual nature of the bereavement process (Bailley, Kral, & Dunham, 1999) two foundational bereavement theories, psychoanalytic theory and attachment theory, from which subsequent theoretical postulates stem, are still dominant in the literature (Jeffreys, 2005; Stroebe, 1992, 2002; Stroebe & Schut, 2001). Developing out of the psychoanalytic and attachment theories of bereavement emerged several stage models followed by some task models. The most notable stage model was developed by Elizabeth Kübler-Ross (1970), which she presented in her book *On Death and Dying*. William Worden's four tasks of mourning served as the preeminent task model for normal bereavement experiences (Walsh-Burke, 2006).

Psychoanalytic Theory of Bereavement

Freud's early writings about grief in his paper *Mourning and Melancholia,* in which he coined the term 'grief work', was based on his clinical experiences (Parkes, 2001). Freud's seminal paper paved the way for future discussions and research in the field (Stroebe & Schut, 2001). Freud contended that grief served the psychological function of divesting oneself from the deceased, termed decatharsis (Walsh-Burke, 2006). Thus, by talking about the deceased and reviewing certain memories, the bereaved would come to an understanding that their loved one no longer existed. When that realization occurred, the libidinal energy that had been subsumed in the grief work process was released and became available for investment into new and maintainable relationships (Stroebe, 1992).

The concept of grief work has remained in the current psychodynamic conception of bereavement (Stroebe & Schut, 2001). According to Bateman (1999), "detachment is the psychodynamic process associated with resolving the issues of loss" (p. 143). People who have not learned how to detach from their lost loved one or object have difficulty resolving their grief (Bateman, 1999). Therefore, the grief work embarked on now primarily serves to help the bereaved divest their energy from the loss itself and invest their energy in processing the significance of the feelings, thoughts, and emotions associated with their relationship to the lost loved one or object (Stroebe & Schut 2001).

Attachment Theory of Bereavement

Bowlby's attachment theory, influence by the psychoanalytic perspective, essentially argued that human infants develop emotional attachments to their primary caregivers, which results in a preference for their primary caregivers over other caregivers. When infants are separated from their primary caregivers, they become distressed. Similarly, adults develop forms of attachments that, when broken, also cause distress (Jeffreys, 2005; Parkes, 2001; Shaver & Tancredy, 2001). Bowlby's attachment theory resulted in several bereavement constructs. First, in 1970, Bowlby and Parkes jointly published a "descriptive classification of the phases of grief, which comprised (a) numbness, (b) yearning and searching, (c) disorganization and despair, and

(d) reorganization" (Parkes, 2001, p. 30). Like the stage and task models that followed, Bowlby and Parkes' work described the classifications of normal grief. Ainsworth, following in the tradition of Bowlby, established her demarcation of attachment patterns or styles (Shaver & Tancredy, 2001). Attachment styles have also been linked to the process of bereavement, explaining why some people experience bereavement in more functional ways than others (Jeffreys, 2005; Stroebe, 2002). Consequently, differences in attachment styles are thought to account for differences in grieving styles (Shaver & Tancredy, 2001).

In essence, attachment theory places working through grief as pivotal for the development and maintenance of future attachments (Freeman, 2005; Parkes, 2001; Shaver & Tancredy, 2001; Stroebe, 1992, 2002). The working through of one's grief is accomplished by reconstructing one's relationship with the deceased in order to continue the bond despite the physical absence (Stroebe & Schut, 2001). According to Maltsberger (1992), clinicians' successful processing of client suicide is contingent on working through the lost attachment to the deceased client.

Stage Models of Bereavement

When bereavement models were first gaining acceptance in the literature, many followed a stage progression (Stroebe & Schut, 2001). While bereavement is now often viewed as a spiral process with phases being revisited in different orders, the initial models deserve credit for providing the foundation for the current construction of bereavement (Jeffreys, 2005). One of the most profound and enduring contributions to bereavement literature was Kübler-Ross' pioneering grief model (Freeman, 2005; Kneiper, 1999; Stroebe & Schut, 2001). Kübler-Ross' model (1970) was developed through her work with palliative care patients and their families. The model is divided into five stages that describe the parallel grief reactions of both the individual who is dying as well as the survivors of that death. The model begins with denial and isolation. This is followed by anger, which is "displaced in all directions and projected onto the environment at times almost at random" (Kübler-Ross, 1970, p. 50). Bargaining in an attempt to change the current reality is next. Depression occurs after bargaining has been unsuccessful. Finally comes the process of acceptance (Kübler-Ross, 1970). Kübler-Ross did not necessarily mean for each stage to be processed through in linear formation but that is how her model was interpreted because of the demarcation of stages (Worden, 2002).

Task Models of Bereavement

William Worden developed one of the most well-known task models of bereavement (Stroebe, 1992). His model built upon the work of Freud, Bowlby, and Parkes (Worden, 2002).

The first task is that of accepting the reality of the loss. Family and social rituals facilitate the movement through this first task. Second, the bereaved need to work through the pain of their grief. By experiencing the myriad of feelings that accompany the grieving process rather than suppressing or denying them, bereaved individuals can regain healthy methods of functioning. The third task is adjusting to the absence in the environment left empty by the deceased. Fourth, individuals work to emotionally move on with their lives and find ways to stay connected with the deceased without feeling stuck in the grief.

Criticisms of Stage and Task Models

Stage and task models have been criticized because they do not account for cultural and individual differences (Bailley et al., 1999; Freeman, 2005; Neimeyer, 2001; Valente, 2003; Walsh-Burke, 2006). Culture and spirituality both play a significant role in individual grief experiences (Jeffreys, 2005; Walsh-Burke, 2006). Formulated tasks or stages imply a shared understanding of the bereavement process (Bailley et al., 1999). More recently multiple expressions of loss have been accepted as natural, normal components of the grief process. Neimeyer (2001), for instance, describes a constructivist approach for working with loss and grief through which clients are supported to develop their own "narrative of loss in a way that promotes a new sense of coherence, continuity, and consensual validation of an enlarged identity" (p. 290). Individual processes and differences are now being considered when conceptualizing normal versus complicated or simple versus complex grief.

Normal Grief

A wide range of physiological responses, cognitions, and behaviors are encompassed in what is considered normal reactions to grief (Jeffreys, 2005; Walsh-Burke, 2006; Worden, 2002). Those reactions manifest in response to an individual's "cultural backgrounds, social support networks, gender, socioeconomic status, as well as psychological health and the circumstances of the loss" (Walsh-Burke, 2006, p. 48). Psychological factors, personality variables, and past loss experiences all influence how grief is processed (Freeman, 2005). Usually over time, though, the intensity of those grief responses diminish (Walsh-Burke, 2006; Worden, 2002).

Complicated Grief

Complicated grief occurs when normal grief processes and tasks go unmet (Jeffreys, 2005; Knieper, 1999 Walsh-Burke, 2006). Complicated grief is often categorized as pathological grief, masked grief, chronic grief, exaggerated grief, or delayed grief (Worden, 2002). Pathological grief is the deviation from societal norms and mourning rituals (Stroebe et al., 2001; Worden, 2002). Masked grief presents when individuals experience symptoms that cause them difficulty but do not recognize them as grief reactions. Masked grief often surfaces through physical symptoms or maladaptive behaviors. Chronic grief is a prolonged state that causes concern (Freeman, 2005; Worden, 2002). The intensification of the grief response cues individuals that the normal process of grief has gone askew. Exaggerated grief refers to an intensity of grief response that is so elevated that it becomes debilitating (Freeman, 2005; Worden, 2002). Delayed grief is grief that is inhibited or suppressed for a variety of reasons (Stroebe & Schut, 2001; Worden, 2002).

Complicated grief can be fostered within certain institutional settings and school systems are one such setting (Rowling, 1995; Schmidt, 2003). Rowling (1995) conducted a study on two schools in Australia that both experienced traumatic events involving students. Approximately 50 teachers were interviewed to elucidate the teachers' experience of the traumatic event and its aftermath. Rowling determined that a significant portion of teachers had experienced disenfranchised grief, which is a form of delayed grief. Disenfranchised grief occurs when a person's grief cannot be openly acknowledged (Freeman, 2005; Rowling, 1995; Walsh-Burke, 2006). Medical, pastoral, and school personnel as well as children, mentally ill, and gay partners have all been cited as disenfranchised grievers (Jeffreys, 2005).

The opportunity for disenfranchised grief was created for teachers in Rowling's study by the presence of several circumstances. First, "teaching involves human interactions, personal connections exist between teachers and students" (p. 321). Second, teachers held particular "professional beliefs—the need to control your emotions, to be in control of the situation and to provide leaderships" (p.321). Third, teachers have an elevated "duty of care for young people" (p. 321). Rowling's findings could be extended, in part, to predict the experiences of school counsellors facing traumatic events in the school, as "[t]eachers in this study . . . performed a role very similar to that of other helping professionals" (p. 325). Rowling went on to note that teachers' grief responses were heightened by the dual roles teachers engaged in with students—coach, supervisor, mentor. Unfortunately, Rowling noted: "there is no description in the literature to date, of the complication this dual role can create" (p. 325). The multiple roles discussed in Rowling's study are similar to the multiple roles held by school counsellors.

Unique Elements of Suicide Bereavement

Suicide bereavement experiences can be distinguished from other forms of bereavement by the violent nature of the death and the violation of societal norms (Bailley et al., 1999; Berman et al., 2006; Freeman, 2005; Jordan, 2001; Silverman, Range, & Overhoser, 1994). "Researchers have suggested that suicide poses greater difficulty for bereaved survivors than do other modes of death, in part because a suicide may be unexpected, potentially preventable, and stigmatized" (Valente, 1993, p. 617). While the term suicide survivor was originally reserved for family members and close friends (Berman et al., 2006; Jordan, 2001; Parrish & Tunkle, 2005; Richards, 2000), it has recently expanded to include "coworkers, teachers, classmates, and therapists" (Knieper, 1999, p. 354). Suicide survivors have multiple experiences to process as they are grieving the loss of the deceased, have endured a traumatic experience, and typically suffer the stigma that interferes with traditional mourning rituals (Berman et al., 2006). Thus, suicide can be one of the most challenging bereavement experiences to process and can therefore result in complicated grief (Freeman, 2005).

Suicide bereavement researchers consistently maintain the uniqueness of suicide bereavement and have worked to tease out the differences between bereavement of other forms and suicide bereavement (Jordan, 2001; Kneiper, 1999; Silverman et al., 1994; Valente, 1994; Worden, 2002). Jordan (2001) identified two main differences between suicide bereavement and other bereavement types. He noted that suicide survivors struggle more with the meaning-making process around the death. Guilt and blame are also higher for suicide survivors who question why they did not foresee the suicide and prevent it.

Stigmatization is a significant factor in suicide bereavement that is not commonly experienced in other types of bereavement (Allen, Calhoun, Cann, & Tedeschi, 1993; Freeman, 2005; Jordan, 2001). According to Jordan (2001): "There is considerable evidence that survivors feel more isolated and stigmatized than other mourners and may in fact be viewed more negatively by others in their social network" (p. 93). Social support is key for suicide survivors as the bereaved often internalize as much stigma as they experience externally (Freeman, 2005). In terms of social support, van Dongen (1993) as cited in Jordan (2001) found that bereaved individuals "worried more about what others really thought of them, felt uncertain about how to act and what to share with others, and believed that community members were likewise uncertain about how to behave around them" (p. 93). Jordan also found that suicide survivors were more likely to lie about the cause of death than in any other bereavement situation.

Burnout

When clinicians do not process their experiences of client suicide in a healthy way, they may find that their professional work becomes unfulfilling, unsatisfying, and compromised in addition to the personal impact of the loss (Fox & Cooper, 1998; Maslach, Schaufeli, & Leiter, 2001; Valente, 1994). Recently, a connection between stress in psychotherapeutic practice and the propensity for job burnout has been acknowledged (Arvay & Uhlemann, 1996; Everall &

Paulson, 2004; Morrissette, 2000). However, studies of specific counselling settings and their relationship to burnout have not been prevalent: "there have been few attempts to delineate the specific negative factors that contribute to stress and burnout among public school counselors in particular" (Kendrick & Chandler, 1994, p. 1). Bereaved clinicians sometimes detach from their clients or limit their contact with clients who present with suicidal ideation (Berman et al., 2006; Fox & Cooper, 1998; Hendin et al., 2000). Both of these responses to client suicide fit with what the literature describes as job burnout (Maslach et al., 2001).

The term *burnout*, in reference to employment, gained popularity during the 1970s among the human services sector in the United States (Maslach et al., 2001). While the literature on burnout has expanded since its introduction in the 1970s, there remain essentially three main components: exhaustion, depersonalization, and reduced efficacy (Maslach et al., 2001). Exhaustion is at the core of job burnout. Clearly, it is one of the more overt qualities and often the one that the affected individual and close colleagues recognize first. Working therapeutically with highly needy clients, such as suicidal clients, is emotionally exhausting (Cerney, 1995). Depersonalization often occurs in response to exhaustion. The process of depersonalization in a counselling context results in clinicians disconnecting from the empathic, emotive dimension and functioning more mechanically in the counselling relationship (Figley, 1995). The relationship of inefficacy to exhaustion and depersonalization is more complicated as it can be a response to either exhaustion or depersonalization (Maslach et al., 2001).

Clinicians experiencing burnout may find that they become ineffective helpers unless they seek services for themselves (Cerney, 1995; Everall & Paulson 2004). Levels of stress and burnout rates are reported as higher for younger employees (Arvay & Uhlemann, 1996; Fox & Cooper, 1998; Maslach et al., 2001). Arvay and Uhlemann (1996) suggest that novice counsellors may experience more stress because they have not put the protective measures in place that their more experienced counterparts have. Higher levels of stress and burnout rates for younger clinicians correspond with some studies that have investigated the impact of suicide on mental health professionals (Chemtob et al., 1988; McAdams & Foster, 2000) and contradict others (Hendin et. al, 2004; Terry, Bivens & Neimeyer, 1995).

Fox and Cooper (1998) reported that clinicians working with "chronically needy clients" (p. 146) find their work emotionally draining, confront feelings of inadequacy, and experience isolation. Kendrick & Chandler (1994) cited job expectations/demands, administration, student crises, students' families, abuse cases, and time management as the key stressors reported by school counsellors. Working with suicidal clients was identified by experienced clinicians as the most distressing scenario out of 15 clinical scenarios presented in a research study (Terry, Bivens & Neimeyer, 1995). Given the climate in which they work, clinicians are at risk for experiencing stress, fatigue, and burnout (Morrissette, 2000).

Secondary Traumatic Stress

O'Halloran and Linton (2000) reported that in recent years researchers have moved from studying counselling and job stress or burnout to exploring the relationship between counselling and secondary traumatic stress. Secondary traumatic stress shares similarities with vicarious traumatization and compassion fatigue (Figley, 1995). Clinicians who are exposed to clients' trauma and are impacted by certain images, stories, and feelings may experience symptoms similar to their traumatized clients (Fox & Cooper, 1998). In a review of the secondary traumatic stress literature, Arvay (2002) noted secondary traumatic stress is a "distinct construct from burnout" (p.290). Secondary traumatic stress occurs when clinicians are unable to separate themselves from their clients' trauma. The onset may be sudden, unlike the gradual process of burnout (Figley, 1995). Those mental health professionals who do not successfully integrate and work through their stress may find that their work becomes compromised (Everall & Paulson, 2004).

Dutton and Rubinstein (1995) described secondary traumatic stress by breaking it down into three components. They started with indicators of psychological distress. Indicators of psychological distress included the felt sense of distressing emotions and intrusive images, an unusual detachment from clients, somatic concerns, addictive behaviors, and general impaired functioning. Next, Dutton and Rubinstein addressed cognitive shifts. These cognitive shifts included pronounced cynicism, changes in perceptions of power and trust, and changes in how clients' narratives in counselling are interpreted by the clinician. Personal and professional impacts were noted by affected clinicians through what Dutton and Rubinstein termed relational disturbances. Clinicians began to create distance in their personal lives, or, conversely, were over-involved with their clients and became consumed with work.

Literature Review Summary

As suicide rates for youth continue to increase, mental health professionals will be faced with the task of working with youth in prevention, intervention, and postvention capacities (King et al., 1999; Laux, 2002; Lockhart & Keys 1998; Schmidt, 2003; Westefeld, 2000). School counsellors are mental health professionals who care for suicidal youth. However, the role of school counselling until recently has been one of providing guidance rather than personal counselling (Ballard & Murgatroyd, 1999). When professional school counsellors experience the suicide of a client, the impact permeates both their professional and personal lives (Hendin et al., 2000; McAdams & Foster, 2000; Weiner, 2005). That experience of loss cannot be fully grasped through quantitative inquiry, yet a number of studies conducted with psychiatrists, nurses, and psychotherapists have attempted to do so (Chemtob et al., 1988; McAdams & Foster, 2000; Menninger, 1991). Further, while school counsellors share some commonalities with other mental health providers, their position is unique (Baker & Gerler, 2004; Barwick, 2000; Heller, 2000; Schmidt, 2003). As school counsellors are now distinguished from other metal health professionals through their work setting and not their practitioner role (Kendrick & Chandler, 1994), school counsellors' experiences of client suicide warrant independent investigation.

CHAPTER THREE

METHOD

The purpose of this study was to explore school counsellors' experiences of client suicide. The qualitative method used in this study facilitated understanding these experiences. The following chapter is divided into sections that describe participant selection, data collection, data analysis, and evaluation of the study. In sum, participants were selected through purposeful sampling, data were collected primarily through in-depth interviews, and thematic analysis was used to present the data.

Qualitative Research

Creswell (1994) circumscribed the qualitative tradition well, arguing that qualitative research is an "inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting a detailed view of informants, and conducted in a natural setting" (p.1). Central to the tradition of qualitative research is the affirmation of multiple subjective realities, "which are individually and communally created" (Arvay, 2002). Thus, the constructivist nature of qualitative research leads one to question the feasibility of studying the other without studying ourselves (Fiske, 1998). If we cannot separate the other from the social fabric in which we are all bound, then as Fiske aptly stated: "We study the other to learn about ourselves" (1998, p. 381). Therefore, this study in many ways represents my evolving understanding of the client suicide experiences of the selected participants.

There are essentially three theoretical perspectives that qualitative methods have evolved from (Merriam, 2002). The interpretive perspective aims to understand the phenomenon. Phenomenology, hermeneutics, and a basic interpretive qualitative study fit well within this perspective. The critical perspective focuses on how "larger contextual factors affect the way in which individuals construct reality" (p.4), while the post-modern perspective questions "all aspects of the construction of reality, what it is and what it is not, how it is organized, and so on" (p. 4). As this study ventured into undocumented territory, the purpose was to explore the experiences of school counsellors who lost clients to suicide and the impact of those experiences. The interpretive perspective, therefore, was the most appropriate one through which to achieve this purpose.

Methodological Framework

This study fits, methodologically, under the umbrella of a basic interpretive qualitative study. Participants were selected through what Merriam (1998), Stake (1995), and Lincoln and Guba (1985) refer to as purposeful sampling. Data were collected through in-depth interviews and then thematically analyzed. In this study, the data is presented through themes that reflect each participant's experience.

While there are many ways to conduct qualitative research, all qualitative studies draw upon the contributions made by both phenomenology and hermeneutics (Laverty, 2003; McLeod, 2001). According to McLeod (2001):

> Any method of qualitative research involves the use of phenomenological and hermeneutic strategies for constructing meaning. In the end qualitative research is a matter of finding the right balance, in the particular circumstances of each study, between phenomenology and hermeneutics." (p. 62).

Hermeneutic and phenomenological traditions both reject the notion of identifying "reality as something separate from the person" (Laverty, 2003, p. 2).

In a basic interpretive qualitative study, as in phenomenology and hermeneutics, the researcher is the primary instrument and meaning is socially constructed (Creswell, 1998; McLeod, 2001; Merriam, 2002; Moustakas, 1994; van Manen, 1998). In hermeneutics, the interaction between the micro and the macro in interpretation is termed the hermeneutic spiral, which is characterized by its forward and backward arcs (Ellis, 1998). The forward arc comprises the researcher's preconceived notions and understanding of the research topic. The backward arc requires researchers to review their initial interpretations and to see what was previously unseen in the data. The backward arc also provides researchers the opportunity to clear up contradictions and to pursue those elements that have been newly exposed through a re-initiation of the forward arc in order to more fully understand the meaning of the experience (Ellis, 1998; Laverty, 2003; Smith, 1991).

Basic Interpretive Qualitative Study

Merriam (2002) outlined the key features of a basic interpretive qualitative study as exploring participants' interpretations of their experiences, exploring the meanings they make from their experiences, and discovering how they have constructed their worlds. The purpose of this type of study is to understand the participants' experiences and the meanings that they draw from those experiences. Merriam (1998) explained this purpose, stating:

> Many qualitative studies in education do not focus on culture or build a grounded theory; nor are they intensive case studies of a single unit or bounded system. Rather, researchers who conduct these studies, which are probably the most common form of qualitative research in education, simply seek to discover and understand a phenomenon, a process, or the perspectives and worldviews of the

> people involved. (p. 11)

While discovery is a basic premise of qualitative research, some qualitative methods, such as grounded theory and phenomenology, have further aims of developing theory and reducing data to its essences (Creswell, 1998).

Data Collection

In this study, data were collected from seven school counsellors. Data were gathered through what Merriam (2002) identified as a basic interpretive qualitative study, which stipulates: "data are collected through interviews, observations, or document analysis" (p 38). Interviewing was the primary source of data collection. Each participant was interviewed twice for approximately one hour each time. The follow-up interview was conducted between one and three weeks after the initial interview. All interviews were audio-recorded and then transcribed. Once the follow-up interview had occurred, transcripts were sent to participants for review and participants had the opportunity to revise and edit their interview transcripts. After the data analysis and writing process was complete, participants were sent chapter four (Findings) to review. At that time, they were also invited to write a response describing their experience of reading chapter four and/or their experience of participating in the study. These responses are included at the end of chapter four.

Participant Selection

Participants for this study were selected through the process of "purposeful sampling [that] is based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned" (Merriam, 1998, p. 61). School counsellors have the opportunity to engage in multiple counselling relationships with clients as they are mandated to provide students with personal, social, educational, and career counselling (Erford, 2003). For the purpose of this study, though, the counselling relationship was defined as one where school counsellors engaged in personal counselling with clients. In addition to the personal counselling relationship requirement, the inclusion criteria for participation in this study stipulated that participants: a) are/were a school counsellor b) lost a counselling client to suicide c) received training in the area of educational psychology or counselling d) possessed both an ability and desire to reflect on the experience of losing a client to suicide.

Participant Recruitment

Several methods were used to recruit participants for this study. I emailed the presidents of the school counselling associations in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Newfoundland, Nova Scotia, New Brunswick, PEI, Yukon and the Northwest Territories. I also contacted the Canadian Counselling Association School Counselling Chapter president who was very accommodating in disseminating my information to the internet listserv membership. The emails sent to these organizations requested that the description of the research study and contact information be forwarded to members of their respective school counselling associations. The associations complied with my request or made small modifications before providing the information to their members. Participants were also recruited through advertisements in newspapers, newsletters, and an internet site. I advertised in the Edmonton Examiner, Alberta Teachers' Association Newsletter, British Columbia School Counselling Association Newsletter, and on the Centre for Suicide Prevention and Information website. Personal contacts and word of mouth were also used to notify potential participants about the study. In addition to my own personal contacts, I joined the Survivor Advocates listserv and sent out the information about my study to the other listserv members. In total, thirteen individuals contacted me to participate in the study. Of those thirteen people, seven met the study criteria. Those who were not suitable to participate were academic counsellors of students who committed suicide, college and university counsellors, not engaged in counselling relationships with the deceased students, or teachers filling school counselling positions in their schools.

Methods of Data Collection

In-depth Interviews

Data were collected primarily through in-depth interviews. As Dexter (1970) as cited in Lincoln and Guba (1985) suggested: "An interview . . . is a conversation with a purpose" (p. 268). Thus, interviews were structured to educe the participants' experiences of losing clients to suicide. Embracing van Manen's (1990) understanding of phenomenological human science interviews, the interviews served the following two purposes. Interviews were "used to explore and gather experiential narrative material that . . . serve as a resource for developing a richer and deeper understanding of the phenomenon" (van Manen, 1990, p.66), and "as a vehicle to develop a conversational relation with the participants about the meaning of their experience" (van Manen, 1990, p.66). As the aim of these interviews was to invite participants to share their experiences, their ease and comfort with the interview process was paramount. Therefore, all participants had the opportunity to talk with me by phone prior to the interview process so that rapport could be established, my role in the research study could be clarified, and any questions or concerns could be addressed prior to their participation in the study.

Once informed consent had been obtained, the interview process began. All interviews were audio recorded. Audio-recordings were used to transcribe each interview. As participants came from geographically diverse regions across Canada, all interviews were conducted by phone. While comparisons of telephone and face-to-face qualitative interviewing is difficult to find (Sturges & Hanrahan, 2004), the consensus seems to be that "telephone interviews are not better or worse than those conducted fact-to-face" (Miller, 1995, p. 35). In fact, when discussing sensitive topics, Fenig and Levav (1993) found that participants preferred telephone interviews as they provided some anonymity. Further, telephone interviews eliminated the cost barrier in this study of interviewing participants across the country.

Research Journal

In keeping with the importance of recognizing the researcher in the research context, I kept a journal that allowed me to reflect on the research process in action. In a constructionist study, it is important to acknowledge the impact that researchers have on participants and vice versa. In fact, Clandinin and Connelly (1998) observed that the use of a research journal provides documentation of the situation and the meaning of that situation as it is shaped by the relationship between the researcher and the researched. Moreover, "the researcher's notes are an active reconstruction of events rather than a passive recording, which would suggest that the events could be recorded without the researcher's interpretation" (Clandinin & Connelly, 1998, p. 5). Consequently researchers "have found that keeping a journal, diary, or log can be very helpful for keeping a record of insights gained, for discerning patterns of the work in progress, for reflecting on previous reflections and for making the activities of research themselves topics for study" (van Manen, 1990, p. 73).

Hermeneutic Spiral

In addition to the interviews and research journal, data were perceived through the process of interpretive inquiry as an unfolding spiral. The spiral is composed of a series of backward and forward arcs that propel the exploration and depth of the data collection. Each loop is a distinct element of the study whether that element is a new or refined question, a data collection or data analysis activity, or a new way of viewing a particular data set (Ellis, 1998). The first loop of the spiral in this study was the guiding research questions: What are school counsellors' experiences of client suicide? What impact did the participants feel client suicide had on their lives? Some loops that followed involved the exploration of relevant literature, recruiting participants, conducting interviews, re-interviewing participants, and an immersion in the data itself.

Data Analysis

According to Merriam (1998), in qualitative research data collection and data analysis are not mutually exclusive. In a global sense, data analysis began "while the interviewing [wa]s still under way" (Rubin & Rubin, 1995, p. 226). After each interview, I transcribed it so I could enhance my familiarity with the research data. After transcribing the interviews, I read each transcript while listening to the audiotape to verify its accuracy and then continued to reread each transcript until I gained a sense of the data. After the interview series for each participant was transcribed, the interviews were sent to participants for review. Participants were asked to verify the accuracy of the interviews and to approve the interview transcripts for use in the research study by signing a transcript release form. Participants were encouraged to edit or modify any of the transcript they did not want included as-is in the document.

Once I received the revised transcripts, I prepared the transcripts for data analysis. All of the interview transcripts were loaded into the qualitative program ATLAS.ti 5.0. While I was still responsible for the analysis of the data, the program enabled me to store a large amount of information in one place, highlight and select specific quotations, and search for key words, ideas, and concepts. Using ATLAS.ti.5.0, each interview was read and reread so that codes could be attached to quotations. As Merriam (2002) indicated: "The analysis of data involves identifying recurring patterns (presented as categories, factors, variables, themes) that cut through the data" (p. 38). Therefore, after all codes had been assigned, *code families* were created to house similar codes. Variations between participants' accounts were explored in an attempt to determine the similarities and differences between their experiences. Again, the analysis process was refined further as *super families*, which correspond to themes, were developed to explain the constructs contained within the super family structures. Essentially, participants' themes were "pieced together to form a comprehensive picture of their collaborative experience" (Aronson, 1994, p. 2). Finally, a rationale for the inclusion of the themes was presented by returning to the literature in an attempt to connect the themes to the relevant literature.

Respectful Research Practices

As a researcher, I am primarily accountable to the research participants. Participants need to be protected and their experiences, as shared gifts, need to be honored. I am also accountable to the audience. The intended audience for this study includes those who have lost someone to suicide, members of the academic community, school counsellors, and mental health professionals.

Participant Protection

Participants in this study have been protected through the guidelines set out by the University of Alberta Faculties of Education and Extension Research Ethics Board. Participation in this study was voluntary. Participants had the right to terminate their involvement in this study at any time. Many opportunities were presented for participants to indicate their continued interest or to cease their involvement. Those opportunities included: agreeing to a second interview; signing the transcript release; reading and responding to the Findings chapter. Further, participants were informed of both the purpose and process of this study before they chose to participate. Informed consent was obtained in written form. To ensure their privacy, anonymity was provided meaning that identifiers such as names, schools, and locations were appropriately altered. To protect third parties, names of places of employment and clients' names were changed or excluded. Original documentation was safely stored in a locked facility, monitored only by the researcher. As it was possible for painful issues to surface due to the nature of this study a list of local referrals was prepared for each participant prior to the interviews, though none of the participants required professional service referrals.

Evaluating the Study

As this study fits within the qualitative paradigm, the data presented in this dissertation is the product of "the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry" (Denzin & Lincoln, 1985, p. 8). Qualitative rigor was enhanced in this study by the use of a peer reviewer. The peer reviewer, a research colleague, examined the transcripts, data analysis process and outcomes to confirm that the themes were rooted in the data and not unduly influenced by the researcher's subjectivity. In general, though, evaluators of qualitative research have experienced difficulty as no consistent set of criteria has been established to judge the merit of a basic interpretive qualitative study. For the purposes of this study, there are several ways to assess its quality. It is important that the research question is appropriate for qualitative research. The research question needs to be well situated in the literature, and there needs to be some significance to the study (Merriam, 2002).

McLeod (2001) presented a procedure for assessing the quality of a research study. He offered seven guidelines for determining whether a qualitative study meets the guidelines for publication. The author must make his/her assumptions, values and preconceived notions explicit. Pertinent information about the participants must be described so that their appropriateness for participating in the study can be established. Examples from the data must be provided so the audience can verify that the interpretation is logically extracted from the data themselves. The researcher must have some measures in place for verifying the credibility of the themes. This would include "reviewing the data for discrepancies, overstatements, or errors" or "checking these understandings with the informants or others similar to them" (p. 186). The representation of data needs to attend to the whole and part to preserve the "subtle nuances in the data" (p. 186) while maintaining coherence throughout. An appropriate number of participants have been included to enable the researcher to fulfill her research purpose. The study is presented in such a way that the audience will be able to further its understanding of the topic. All of the preceding guidelines can be considered, and used where appropriate, to inform the audiences' evaluation of this qualitative study.

CHAPTER FOUR

FINDINGS

Seven individuals participated in this study. While geographically spanning the country, representing four provinces, they are connected through the common experience of client suicide. Five participants were teachers first and found that students would congregate after class or before school to talk with them about their personal issues. The personal fulfillment from listening to students led most of the counsellors to return to university for diplomas or degrees in counselling-related fields. Two participants came from social work backgrounds—one went back to school for a teaching degree, while the other had specific training and extended practicum experiences in the school system. All participants were practicing school counsellors at the time of their clients' suicides and continued to practice in that role. These participants shared their personal, powerful, and intense experiences of client suicide.

Introduction to the Participants

Bob

Bob is a school counsellor and former social worker in a large urban center. He is nearing the end of his career and has experienced two client suicides. Bob's first encounter with client suicide occurred two years into his career. He had a lot of support in processing that experience as he was present at his client's death. Approximately ten years later, Bob had a second experience with client suicide. Again, Bob worked with professionals to process his experience as he was in the room with his client, Harvey, when Harvey committed suicide. Bob has used these experiences to support other teachers and counsellors by participating in suicide awareness and prevention curriculum development.

Anne

Anne is a school counsellor in an urban setting. She is also nearing the end of her career with approximately twenty-five years of combined teaching and counselling experience. Prior to becoming a school counsellor, Anne was a classroom teacher. She taught courses related to healthy living and decision-making and found the subject matter to be a natural springboard for adolescents to talk about their issues and experiences. Anne believed that if she was going to talk with students about these issues then she needed further training. After thirteen years in the classroom, Anne went back to university for a master's degree in counselling. She counselled for approximately ten years before her experience with client suicide.

Emily

Emily is a school counsellor in a small city. She is responsible for providing counselling services in several schools. Emily's background is in Social Work rather than Education. However, in her Social Work program, Emily's practicum experience was in the school system. Before becoming a school counsellor, she had been counselling at a private practice in a large city. When a school counselling position opened up in her hometown, Emily was eager to take it. Emily's school district was one of the last in her area to hire social workers as school counsellors. She has now been a school counsellor for fifteen years. At the time of her experience of client suicide, Emily had been counselling in the school system for thirteen years.

Fred

Fred is a school counsellor and the head of his school's guidance department in a small community. With his teaching and counselling years combined, Fred has thirty-one years of experience. Fred taught for approximately fifteen years before he became interested in school counselling. As a coach for some of the extracurricular sports at his school, Fred found that students approached him to talk about their problems. He enjoyed this type of interaction with students, so went back to university to become a school counsellor. Fred had been counselling for a few years when he had his experience of client suicide.

Maggie

Maggie is a school counsellor and the department head of student services in an urban school. She is also on her district's crisis response team and has responded to a number of school tragedies and student deaths. Maggie started her career teaching in a small community. Soon after, she decided she wanted to become a school counsellor and went back to university for some additional training. Maggie has experienced multiple student and client suicides both as a novice and more experienced counsellor. She spoke about her experiences with client suicide in general terms rather than singling out a specific suicide.

James

James is a school counsellor in a medium-sized city with nineteen years combined teaching and counselling experience. During his Education degree, James took a number of classes in psychology. After finishing his degree, he accepted a temporary mental health position where he received some counselling training. When that position finished, James taught for three years and then decided to pursue a career in school counselling. He described the transition as "a natural occurrence" because students tended to talk with him after class about their personal issues. James' first school counselling position was in a small community that had not had a counsellor for several decades. James was in his first year of school counselling when he experienced a client's suicide. After his experience, James had the opportunity to participate in writing his district's emergency response plan.

John

John is a school counsellor and a crisis response team member in a suburb of a large urban setting. When he was teaching, John found that students would open up with him. After several years of teaching John was offered a counselling position, which he accepted. However, John did not have much formal training in counselling so he applied to university and received his post-graduate diploma in guidance and counselling. As a member of his district's crisis response team, John had responded to a number of student deaths at other schools before his own experience of client suicide. John has been a school counsellor for sixteen years. He had been counselling for approximately ten years when his client committed suicide.

Introduction to Themes

The following are the themes that emerged from the research interviews, exemplified through excerpts of our conversations: *Taming the Control Beast; Wearing the Mask; Interpreting the Dance; Staying in the Game*. The following table outlines the themes and subthemes that serve as the template for this chapter:

Themes	Sub Themes
Taming the Control Beast	Encountering Opposition Fighting as a Soldier Losing the Battle Seeing the Image Tarnish Charging Ahead
Wearing the Mask	Being Treated Like an Understudy Meeting of the Masks Staying in Role Washing off the Make-up Standing Alone on Stage Casting New Roles Designing the Set Revising the Script Performing Again
Interpreting the Dance	Finding a Partner Sensing the Rhythm Staying in the Moment Feeling the Final Song
Staying in the Game	Retiring the Jerseys Warming Up

	Developing New Plays Holding their Positions Coaching New Players

Taming the Control Beast

The first theme *Taming the Control Beast* explores the relationship that many participants had with control. As participants' feelings of vulnerability and powerlessness increased, so did their desire for control. Those who relinquished their sense of responsibility did so after accepting their limitations as school counsellors. Participants spoke passionately about their desire to protect their clients. In large part, that protection was about having the ability to take charge, make decisions, facilitate healing, and improve their clients' overall well-being. For two participants, *Taming the Control Beast* meant relinquishing responsibility. For the remaining five participants, regaining control was of paramount importance. Contained within this theme are a number of elements that speak to the relationship participants formed with the construct of control.

Encountering Opposition

Participants were never more aware of the importance of control than when it was out of reach. Three participants reflected on their feelings of powerlessness when confronted with 'the system'. Emily had the opportunity to work with her client, Ryan, over a number of years. There came a time in their counselling relationship when Emily realized certain safeguards needed to be put in place to protect Ryan. This realization initiated a draining, disappointing court process. Even though her testimony alienated Ryan, Emily persevered because she so desperately wanted to keep him safe. Despite her best efforts, Ryan was returned to his toxic home environment. His eventual escape came when he committed suicide. Emily spoke about the frustration and anger she directed at 'the system':

> I was angry at the system. I was angry that the judge couldn't turn around and say to ** (guardian) 'you're dysfunctional, you're an alcoholic, most of your kids have been screwed up. I'm not going to let you screw up another generation'. That's kind of what I wanted him to say. I know that if Ryan had stayed in foster-care, he wouldn't be dead today. I feel strongly about that and maybe I'm . . . I'm just saying that I feel like the system failed him.

Emily's anger intensified when precious information that may have inspired the court to protect Ryan came out during the police investigation following his death. Unfortunately it was too little too late: "The sad part was I realized there was nothing I could do to use it. I finally had enough evidence to get him out of the home, but it was too late."

Another participant, James, reported similar feelings of frustration and anger that he directed at 'the system'. His anger was borne out of the realization that he did everything he had been trained to do and the system still failed. James fulfilled his professional responsibility of protecting his suicidal client when he contacted the appropriate outside agencies; however, the requested support was not adequately provided and his client committed suicide before any other avenues could be explored. James commented on how his anger affected him:

> I had done what I was supposed to do. I had done what I needed to do, but the system broke down (. . .) and I'm projecting my anger at the system, but there's nothing. Really, what can you do with a system? You don't have the ability to influence the system, so it was hard for me. I don't think it was a very positive anger. I carried a lot of anger for the system. If she had gotten the help that she needed when she should have gotten it, she might have still been alive.

The fateful system Bob encountered was the hospital system. Bob knew his client was imminently suicidal and was thankful that a team of professionals was involved in his client's treatment. However, that appreciation turned to anger when his clinical judgment was discounted. Bob had advocated for his client to continue with in-patient treatment because she disclosed to him that she was tricking the medical staff into discharging her so she could finish the job she started. Bob's client remained true to her word, committing suicide shortly after her discharge.

Three participants wrestled with the belief that if their clients had received the help they needed, they would not have taken their lives. Participants did not think their anger was productive but they felt powerless to positively affect change when facing such solid institutional structures.

Fighting as a Soldier

Of the participants who fought tooth and nail to have some semblance of control, most felt a sense of responsibility for their clients' well-being. That feeling, though, was not experienced by all participants. Two participants willingly released themselves from any sense of responsibility. Fred was one of those participants. He had an opportunity that no other participant seemed to share, as he was able to question one of his clients about the precipitating events leading to a suicide attempt. After client suicide, many school counsellors are left with lingering, unanswered questions. Fred got the answers to his questions before he was faced with a completed client suicide. He recounted working with a suicidal teenager who, in his opinion, was making good therapeutic progress. When Fred later heard about the teenager's suicide attempt, he questioned his clinical judgment. Fred recalled the events that transpired in the hours after his client left his office:

> He was in a situation where he'd been very down, very close to suicide, and then I'd been working with him. He had been, I thought, improving steadily and went home and attempted suicide about an hour after he'd talked with me. That one just floored me. I'm going, 'hey, I'm supposed to know all of these signs, I'm supposed to know what's going on'. Thank goodness he survived. When he came back, we were chatting about it and I asked him. I said 'alright, you really threw me because I don't know what I missed, what was going on'. He said, 'oh, I felt fine when I was talking to you'. On the way home, he said ** (describes an event/situation). He said, 'that was it'. So, there weren't any signs in this, there weren't any things I should have been doing. It was a circumstance that was way beyond my control.

Fred described the significance of his client's attempted suicide. He talked specifically about the gift of solace that experience provided him when he later faced a client's completed suicide: "I think it gave me some comfort saying 'okay, maybe something happened again outside our control that we didn't miss.' " Unbeknownst to Fred, this experience would become profoundly influential in the way he processed the loss of a subsequent client to suicide. Given what he learned from his previous client's attempted suicide, Fred held fast to his assertion that clients are responsible for their choices:

> You can't be with these kids twenty-four hours a day. Things are outside your control with it. You can be there and help any time that they're there, but there are times that they'll make decisions that you don't have any control over. You can do all the things that you believe are the right steps. You can do everything in your power, and if that student still chooses to commit suicide, then you really don't have that much to say about it.

Maggie also expressed her belief that clients, not counsellors, are responsible for the choices that they make. As an experienced school counsellor who has been a crisis team member for many years, Maggie has worked through the process of healing from client suicide with many colleagues, bereaved parents, and classmates. Her multiple experiences of client and student suicide have taught her that she cannot control the choices adolescents make. That realization has taken considerable time to reach. Maggie talked about how her perspective has evolved over the years:

> Originally I used to take it personally. I used to feel that I didn't do my job well enough and I lost that client, and it's my fault. I didn't do enough for that student. I now know that suicide comes as a result of a feeling of hopelessness, helplessness, a feeling of despair, a feeling of 'this is the end of the world and there is no solution to my problem'. I don't take it personally anymore and I tell that to my students.

The two participants who relinquished their sense of responsibility were both experienced counsellors. They had worked through the process of understanding adolescent suicidal behavior before being confronted with their own clients' completed suicides. Fred and Maggie's previous experiences made relinquishing their sense of responsibility possible.

Losing the Battle

The experience of losing control was incredibly difficult for four participants as it signaled the transition from being in a position to make decisions and effect change to being unable to influence external factors. Geography was the external factor responsible for James' loss of control. Even though James had recently moved, he continued to counsel one of his clients by distance in order to provide continuity of care while facilitating her transfer to the new local school counsellor. After his client's death, James was not in a position to regulate how the school marked the girl's suicide because he was removed from the school community. He was frustrated with the school's response but could do nothing to alter it. James explained how he felt:

> For me, there was also a huge loss of control because I was dealing with a student that was so distant from me and a situation that was so distant for me, I didn't feel like I was able to control right from the start right to the creating of the award. I had a feeling of loss of control which was very, very frustrating. One of the biggest things, and this is very common in the grieving process if you have someone that is terminally ill or situations like that, is that loss of control. That was a huge part of what I went through.

To compensate for feeling that important matters were out of his control, James worked to gain control over little things. He knew that he could neither change nor control what had happened but he could create the appearance of order by focusing on what was in his command. James outlined how order could be constructed: "one of the things I learned from it, that we are beings that need to control, but when you get into these situations, there's a total lack of control so you need to establish small ways and understand what you can control and what you can't."

Anne and John were also controlled by a powerful external factor—the possibility of litigation. While they felt the personal loss associated with their clients' suicides, both experienced the fear of professional repercussions and felt professionally vulnerable despite their adherence to best practice methods. Very soon after she found out about her client's suicide, Anne contacted a lawyer:

> I phoned a lawyer, before I phoned the ** (agency) that I was supposed to call. I thought, 'am I going to be in trouble? Am I going to get charged with something here? What's going to happen to me?' I was really afraid. And he [the lawyer] reassured me that I wasn't in trouble, and that he would be there for me no matter what happened.

Anne found the lawyer to be one of the most comforting, supportive professionals she dealt with during the aftermath of the suicide. Not only was she dealing with a personal loss, Anne was also afraid that her career could be in jeopardy. Having the lawyer's assurance that she did nothing wrong and that she was not in trouble enabled her to focus on the personal loss she had experienced.

John also spoke about his fear of being blamed for his client's death. He admitted that he played the 'what if' game, questioning what he could have done differently or what he may have missed. He feared that others would hold him accountable too:

> It's difficult in that I find that I go for a stretch of time where I'm very business and I'm thinking, and then I lapse into a couple of different feelings. Certainly one of them is a sense of sadness, obviously, and loss. But also, to be honest, I'm going to be really honest with you, I switch into a fear that I have that I will be accused of screwing up somehow.

Though Bob did not talk specifically about fear of legal action, he did spend a long time sorting through the details of Harvey's suicide and consulted with other professionals to determine if he should accept any responsibility for the events that unfolded. Bob stated: "I spent many years trying to figure out if I caused his death. I went over with the police, I went over with the suicidologist exactly what took place."

Participants described how their self-confidence was temporarily shaken after experiencing their clients' suicides. Participants had to work through their own insecurities so they could face future clients. For two participants it was important to have another professional reassure them that they were not responsible for their clients' suicides. The remaining participants found independent ways to comfortably regain their lost sense of control.

Seeing the Image Tarnish

Losing a client to suicide really challenged five participants' self- perceptions. Participants chose to enter the profession because they truly believed they could help young people. When they lost their clients, participants experienced some uncertainty in their abilities:

Bob:	What it did for me was shatter in many ways the perception of who I was.
Anne:	I was afraid that the kids wouldn't ever want to talk to me again. That they would be really angry with me, and that nobody would trust me.
Emily:	I'm glad that he's in a different place, away from those people. I think for me, there is that peaceful side. The other side is that it makes me a little scared sometimes to do my job.
James:	So I never contracted with her because I trusted the other professionals to do it. Then for about two years after her suicide I questioned 'what if I had contracted with her? Would she still be here if I had contracted with her?'
Maggie:	I used to feel that I didn't do my job well enough and I lost that client, and it's my fault. I didn't do enough for that student. I now know that suicide comes as a

> result of a feeling of hopelessness, helplessness, a feeling of despair, a feeling of 'this is the end of the world and there is no solution to my problem'.

Two participants spoke about how difficult it was for them to recognize that not all tragedy can be prevented and that adolescents may still choose to die despite school counsellors' best intentions. Anne's ability to support her client was limited in that she could not change the home situation: "Now I remember having a feeling of helplessness too. I didn't know what to do for her. I mean, I felt . . . I can't change her circumstances." Similarly, Bob discovered the greatest enemies his suicidal clients faced were themselves from which he could provide no protection. Bob explained:

> I had to work through the fact that I felt like a failure. In many, many ways I was blaming myself for her death because . . .I don't know how many counsellors have this feeling, but being young, being enthusiastic, I thought that I could save anything.

Several participants lamented the lack of opportunity they had to intervene in their clients' suicides. Bob came as close as possible to interceding as he was present at two of his clients' suicides, yet even with his proximity, he remained powerless to change the decisions his clients made to end their lives. Bob was confronted with his powerlessness in a most painful, unimaginable way. The notion that he could save his clients died the day one of his clients plainly stated that Bob could neither change the course of her life nor prevent her death. Bob recalled that interchange:

> So, sure enough, a couple of weeks later Christmas vacation is over and we're back in school and who shows up for class but this young lady and um she comes into my office and she says 'well, I'm back' and I said 'it's good to see you and I hope things are better and I'll always be here for you if you need me'. And she says 'oh, I'm going to need you alright.' I said 'that's what I'm here for' and she said 'oh no, I'm going to finish off what I should have finished off that day. Only this time you're not going to save me.

Bob endured an additional heartbreak with his client, Harvey. In the hours preceding his suicide, Harvey reached out to Bob. They spent a long time talking, reminiscing, and dealing with some intense emotions. That connection left Bob unprepared for the final decision Harvey made:

> I really felt that I could . . . I don't want to use the word "save". I really felt that I could help Harvey. I really felt that he was going to come out of the room and get the help that he needed. That he was going to put the gun down. He was laughing for God's sake. I don't equate the fact that you're laughing with someone who's in the room with you, that you're going to blow your bloody head off.

One of the many difficult aspects of suicide these school counsellors grappled with was the powerlessness they felt in response to their clients' suicidal behavior. That powerlessness flew in the face of what they imagined school counselling to be. They could not change the life circumstances their clients faced, they could not control their clients' environments, and they could not inspire hope during their clients' moments of desperation.

Charging Ahead

Most of the time school counsellors are comfortable being in leadership positions. They have been well trained in interpersonal communication and are skilled responders to high-risk situations. Therefore, it was not surprising that in the aftermath of the suicides participants adopted a leadership role either by choice or by necessity,

When Anne heard about her client's suicide she was devastated. Immediately she found herself on board an emotional roller coaster—panicked about the next school day and how people would respond, heartbroken that her client chose suicide, and frightened about the security of her own professional future. She felt that she was in no condition to organize the school's postvention protocol. The school, though, was not prepared for the crisis response leader to be in crisis herself. Consequently, no one came forward to relieve Anne of that crisis response duty. Anne talked about how it felt to be forced to take on the leadership role at a time of personal crisis:

> And how I was going to stay in this school feeling that this school didn't know how to handle crises. That I was going to have to be the one that they were going to count on to rally the troops and get things under control. I didn't want that role. I knew it was crazy. I was so angry. I felt this whole this was out of control. It just feels like . . . it's crazy that I'm doing this. But there was nobody else who was stepping up to the plate to do it. I needed to do it.

Other participants chose to take control of their schools' postvention protocols because it enabled them to maintain a professional exterior of strength even when they were crumbling inside. In a chaotic situation, these counsellors worked to create safety for the school community. Emily reflected on a discussion she had with a colleague regarding leadership: "So we talked a lot about the fact that most of us in this profession, when something like this happens, we become very control and power hungry to maintain that strength."

Maggie spoke about the mindset she adopts when confronted with a suicide at her school. Over the years she has refined her process for dealing with student suicide. Maggie candidly shared how she tries to control the spread of chaos; she spoke of grief as the contagion:

> My mindset now is when there is grieving and it's the whole school that is affected, all of the students, all of the teachers, everyone is affected, my mode now when that happens is to take charge and to be in control and to say 'this is where you can grieve, this is what you can do'. I try to set parameters now, whereas before I was probably one of those ones

> wandering around wondering 'gee what are we going to do?' 'how are we going to do this?' Now that I've had the experiences that I've had, immediately I want to take charge . . . that's now my mode. To come in and to treat it as if there was an emergency, as if there was a bomb. Immediately come in and take control and get these kids to places where they can safely do their grieving because it can be very infectious.

Participants held leadership roles during the postvention protocols after their clients' suicides. However, the leadership role did not insulate participants from the raw emotions they needed to process. Some gravitated towards the leadership role because it allowed them to become immersed in the professional process, others reluctantly assumed a leadership role.

Wearing the Mask

Wearing the Mask speaks to the significance of the personal experiences these participants had within their professional contexts. Participants struggled to find a balance between their personal and professional experiences. However, they all creatively found ways to manage their emotions while continuing to serve in professional positions. Some found ways to deal with their personal grief within their schools while others experienced isolation because their colleagues could not comprehend what they had endured.

Being Treated Like an Understudy

Two participants spoke of their absolute frustration and anger at not being valued as mental health professionals. Bob and James had knowledge that their clients were suicidal and needed immediate assistance but their information was passed over and discounted by external agencies. For Bob the experience of being devalued as a professional was foreign. Prior to returning to school for his teaching degree Bob was a practicing social worker. In that role he enjoyed professional respect. Bob described how it felt to be professionally disregarded in his new role as a school counsellor:

> One thing that I learned very quickly because this was basically my first encounter with professional agencies and they were bound and determined to let me know that 'your just a school counsellor' I felt like I was being put down because I had all these years of being a counsellor. As a social worker I had worked in really tough situations and someone's telling me 'you're just a school counsellor. We'll take it from here' and I felt slighted, really did. Consequently my voice was listened to but I could see that I was basically sometimes an irritant.

James understood what it meant to be 'just a school counsellor' as he fought to be heard by the local social service agency. His attempts to communicate information to the agency workers were repeatedly rebuffed. What complicated his situation further was that he was no longer the on-site primary care professional in his client's case. He attempted to connect his client with a local agency after he moved a significant distance away. James detailed one of the many times he tried to access support for his client:

> Again, I re-contacted the resources. I was angry and so I blasted them. I had documented the phone calls. I had everything documented. So I ended up talking to one of the supervisors. There were a lot of excuses why it wasn't happening. I felt at that time that she needed more than just weekly, or every couple of weeks, a visit. Again, they didn't listen to me. And, then she had a second attempt where she almost died.

In the circumstance of client suicide the disrespect and devaluation they experienced became intensely personal for Bob and James. Bob was confronted with the repercussion of medical professionals disregarding his client's suicidal intent:

> It was a cold day in the city and there was lots of snow and, on the ground, and this teacher came to see me and said 'you'd better come quickly right now' because her class was on the second level of the school and from the class she could see out onto the field and she saw this person stumbling, coming back to the school and eventually collapsed on the field, and I ran out of the building, ran through the snow, and sure enough, it was her. I was able to yell back to the principal who was following behind me and I said 'please get an ambulance immediately' because I could see her pupils were rolling back into her head and I said to her . . . this is out of a movie what I'm about to say to you, but I said to her 'what have you done?' and all she said to me was 'Mr. **, please help me' I was I was holding her in my arms, trying to keep her warm, and she passed away. I don't know how long I was sitting there . . . oh wow this is years ago and I can still visualize it . . . and I could hear the ambulance and I remember someone tugging on my shoulder and saying 'you can let go' and I didn't want to let go of her. And they took her away.

Bob felt that the two predominant care-giving groups in his client's life had ignored his clinical judgment. He was angry with the parents for not taking a more active role in their daughter's safety. Bob had told the parents repeatedly that their child was imminently suicidal. He was also angry with the medical staff, particularly the treating psychiatrist, for dismissing the seriousness of his client's suicidal intent. In the end, Bob was left with the penetrating sadness that his client may have been helped if Bob had been listened to.

Meeting of the Masks

Participants in this study represented provinces across the country, practicing in both rural and urban centers. Three participants from rural areas identified working through the dual role dilemma as fairly routine considering they often had contact with clients in multiple settings. Fred, Emily, and James discussed their experiences of working in communities where their roles were intertwined. Fred was able to integrate his teaching and counselling roles:

> I'm in a very small community and I think there are a lot of advantages to that because you know the kids more than just in school as well. I coached in the community as well

> as the school here. You get to know the kids quite well in a lot of different ways. So the counselling part of it just becomes part of your teaching and interaction as well.

Emily consciously worked to separate her personal and professional roles with her client, Ryan. In particular, she tried to limit the times she saw him socially and reinforced the boundary separating her professional work from her personal connection. She conceded that even with some professional boundaries established, "there were a few times when I was involved in some social contexts with him". Having to flip between roles became a personal theme for Emily that served to complicate her grief.

James found the interconnectedness of the personal and the professional less concerning than Emily. He enjoyed the continuing bond with his clients and was honored that his clients interacted with him beyond the scope of his job. James identified what he liked about being seen as a person and a professional: "I think the fact that they feel they can trust you and that you're not just a professional, you're more than a professional."

Participants spoke about the intense reactions they experienced when they found out about their clients' deaths. While they were in professional capacities when they heard the news, it was impossible to contain their personal horror. Emily was sitting in her office when she received the phone call from a colleague. The colleague assumed Emily had already heard the news and was calling to see how she was doing. As she began talking, it became clear to her that Emily was unaware of Ryan's suicide. Emily recalled that phone conversation and the moments that followed:

> She said "Ryan is dead'. I went 'what?' She said, 'you're not going to like this'. She said, 'he killed himself'. All I remember from that point on, which was very odd for me, because usually when I hear distressful news I usually go right into social work mode . . . okay who's affected, who needs to handle things, and that kind of stuff. I let out this very deep cry, scream, that had some other people in the guidance department run into my office. The vice-principal at the time, his office was right beside mine, he heard it. He had gotten this call at the same time. The vice-principal and I weren't as close as we are now. We had just started working together and I think he was quite taken aback that the social worker was falling apart . . . At first it was kind of like, 'oh my God, here's the social worker, who's part of the crisis team, falling apart'.

Anne had returned from holidays and, like Emily, was sitting in her office when she heard the news. Anne was following up on some email requests when she came across an unusual request from a colleague asking her to contact an outside agency regarding her client. Anne emailed the coworker for clarification because she knew that she could not release any information without her client's consent and she was uncertain what the request pertained to.

Anne received a terse email response simply stating that the client had committed suicide with some additional information stating the method and date. Anne remembered what she experienced in the moments after reading the email:

> Jesus Christ. I thought . . . my brain went fuzzy. I sat in my chair and I remember that my whole brain went fuzzy. I couldn't catch my breath. It upsets me even just thinking about it but I thought I can't believe it. I can't believe someone just sent me this email. So I sat there and I just . . . I didn't know what to do. I thought . . . I couldn't even think straight. I knew I couldn't sit in my office, I knew I had to get out of here. I got out of my office and I just paced the hallway and there wasn't anybody around. I just walked up and down the hallway and I just tried to catch my breath. I just thought, 'I can't believe anybody could be that insensitive' and then I thought 'nobody told me'.

James was working in his office when he received the phone call telling him about his client's suicide. He went into shock, replayed the phone conversation in his mind and tried to make sense of the news he had just heard:

> After I set the phone down, I just sat there for about twenty minutes and just tried to digest the information. I went through all the wide spectrum of denial, 'no this can't be true'. I went through the anger, 'how could this have happened in a hospital?' 'Why didn't they do . . .' You go through the whole spectrum of the grieving process in that twenty minutes, you know?

Maggie has experienced several client suicides over the years she has practiced as a school counsellor. She spoke about her response to hearing the news in general terms:

> The gut response is always the same. It's always, you know, the shock, denial, all of the stages that everybody first goes through when they hear. So that's always the same. I can't say that I've had any clients that their loss has been any more devastating than another one. To me, they're all devastating.

Fred already knew about his client's suicide before he came to work that morning. He said:

> It's a small community. I believe that I heard about it when I came to the school in the morning. I'm not exactly sure who told me first, but . . . I remember very clearly that his mother called me to let me know. But I knew before then.

Fred described the feeling he had in the pit of his stomach when his secretary told him that his client's mother was on the phone. He had no idea what frame of mind she was in but expected her to be angry or even to blame him in some way. Instead, she thanked him for the work he had done and invited him to give the eulogy at the funeral.

John described his reaction to hearing that his client had committed suicide in visceral terms: "It was a punch in the stomach. It was quite devastating." He tried to make sense of the information but could not figure out what led his client to commit suicide when John thought his client's life seemed to be getting back on track.

Bob's experience is one that has been forever etched into his memory. What he saw and experienced cannot be more personal, more painful, or more permanent. Bob described what he witnessed:

> All I saw was the gun. I saw the muzzle of the gun go into his mouth and he shot himself. I have incredible nightmares. To this day, at night time, it's like his face exploded and all I remember was blood and remnants . . . it was like someone flung it on me and it was, God, it was the loudest bang. The next thing I know, I had someone grabbing me and I was being pulled out of the room. I don't know what happened. To this day I still don't know what happened. This one I don't forget.

Staying in Role

Six participants kept their emotions at bay. In order to continue performing their responsibilities, theses participants compartmentalized their own experiences and focused on the work tasks at hand. Five participants spoke of their need to operate solely within the professional domain, which forced their grief to go underground. For example, Emily had an intense response when she heard about Ryan's death but did not process that response because she had too much work to do:

> I went right back into my mode which I'm safe with. No crying. Totally in the social work mindset. I don't mean to say that as a social worker we don't care, we just get numb . . .you know, I just thought, for me, it wasn't the time to break down. I did shed a few tears during the service, my eyes watered. I wasn't frozen, but I definitely wasn't there as somebody who needed to grieve. I was also trying to pull myself together because I didn't want the principal and the vice-principal to think that they couldn't count on me through this crisis point . . . so at that point my grief went totally underground. I just remember wiping away the tears. I didn't have another thought about my feelings at that point.

In a similar vein, John kept his emotions out of the workplace because he thought there was too much work for him to be doing with others. Therefore, his own emotional processes were put aside. While he recognized the value of dealing with his own emotions, he suggested that his focus on the external environment afforded him the opportunity to gain some perspective on his own emotional process. John explained:

> So therefore your emotion, in many situations, you can't afford for it to enter in. At least to keep that in mind. I don't know whether that's truly processing it or that's just putting it away for a while. Though I do find that sometimes putting away your emotion for a while, it does diminish.

Like John, James viewed grief as a luxury he could not afford. He did not think that he had enough time or energy to deal with his own feelings of grief: "Well I didn't have the time to grieve. I had to be strong for everybody else right? I had to be strong for the students." Fred, on the other hand, did not purposely suppress his feelings although they were never overtly expressed. He experienced sadness with the loss of his client but admitted: "I honestly don't remember dealing with it at any special point."

Maggie gained some insight into her own internal grief process during the course of this research study. She spoke of keeping a professional focus to avoid feeling her own sense of loss. When she thought more about how she handled the loss of her clients to suicide, she realized that her motivation for remaining in the professional role had been to mask her own grief:

> You hold back the tears and put on a front that you are very strong and that you know what you are doing. I guess what it allows me to do is to not have to deal with my own grief. I take on another role. I take on a role of taking charge for what's happening in the school. That's causing me really to reflect quite a bit because I guess I've done a lot of really good covering up over the years. I've never had a situation where I've said, 'I can't go there' or 'I can't do that'. I've just always done it. I guess, you know, I'm asking myself 'when do I do my grieving when I've had suicides?'

For two participants, keeping their emotions at bay helped them protect their vulnerability. Anne initially opened up to a colleague but found that he did not know how to handle her emotions. Further, she quickly realized that her staff did not know how to handle the postvention protocol. Therefore, she suppressed her emotions while at work:

> I realized very quickly that I just couldn't get the kind of support from him [colleague] that I needed. So, I just shut down. I stopped. And I think I just couldn't believe how isolated I was starting to feel. I told [another colleague] as well. She was sympathetic, but I could tell that she really didn't know what to say to me either. She was uncomfortable with how upset I was. I started to get really scared. I thought nobody around me knows what to do with this.

Because her colleagues did not grasp Anne's need to process her loss, they did not come forward to facilitate the postvention protocol. Amidst her own grief, Anne needed to provide support to the other staff and students. Enacting the postvention protocol became overwhelming for Anne given her own emotional connection to the deceased student. Anne shared some of the protocol she put in place:

> So, I did it. I made phone calls to teachers, the ones that I figured were close to her [deceased client]. From there, I got more information. I got names of kids we thought might be at risk. I found out about the funeral and what had happened and who had been there. I wrote a script for what the staff could say to the students and I got pamphlets and handouts on grief and suicide and warning signs. I got a bunch of stuff together and got

> together with a couple of the teachers who were close to her and felt that we needed to do something. I arranged for a crisis debriefing session. I'd never done one before. I realize now that we should have gotten some outside help to do this, but I didn't know that then. I got it together and thought that this was absolutely bizarre. I'm the person in crisis and I'm the one doing the crisis response.

Maggie reflected on the tenuous balance between feeling safe to share emotions and an unspoken obligation to maintain a polished, professional veneer. As a novice counsellor, Maggie did not have a mentor to guide her through the loss process. Consequently, she was never sure when and where she could express her grief. Over time she found funerals to be a place where she could grieve in a contained, confined space:

> Originally for me it was 'what's okay and what's not okay for a guidance counsellor'? in terms of showing any emotion around grieving, which now has taken me to the point now where I only give myself permission to do that at the funeral.

Emily counselled Ryan for a number of years as she worked in both the elementary and secondary schools he attended, which undoubtedly contributed to the close relationship they shared. At a certain point in their therapeutic relationship, Emily became aware that Ryan's safety was an issue. This realization launched an unsuccessful legal battle to secure a safe home environment for Ryan. His suicide spurned a police investigation into the circumstances surrounding his death. Emily was interviewed during the investigation into Ryan's death. In her interview, the police officer, who must have seen Emily as a professional with whom he could confide, started to debrief his experience which forced Emily to flip out of her personal grief and into a professional mode. Emily talked about the impact of that forced role shift:

> The hardest part for me was that I don't think the ** (police) officer knew how personally I was involved with Ryan. I guess he had worked with school counsellors in other events and he just sat down and he started unloading. What happened was that he told me so much information, all the information that I always needed to prove that he was in a very dysfunctional home. All the truth came out in regards to that night I was just wanting to scream inside because I didn't want him to see how upset I was getting because he needed to talk, and it was in a confidential atmosphere, so the ** (police officer), I just felt bad for him. He needed to vent. To this day, I have not shared what the ** (police officer) shared with me the secret, that's been hard for me . . .

Six participants in this study kept their emotions at bay in the aftermath of their clients' suicides. Some made the conscious choice to put the needs of their students and staff before their own needs because it enabled them to suppress their own feelings and create some temporary relief. Others felt their primary responsibility was to serve the school community and therefore attended to others' needs before addressing their own grief. Either way, several participants experienced delayed grief responses to their clients' suicides because they tended to the needs of others before tending to their own.

Washing off the Make-up

Several participants did not know what kind of support they needed from their colleagues immediately after they heard about their clients' suicides but they were aware when that support was absent. Time has provided these participants with the ability to articulate what would have been helpful for them in the early stages of their grieving process. Anne summarized what was captured in a number of participants' responses. She talked about craving a human, emotional connection with those people she turned to in the moments and days after hearing about the suicide. Anne reflected:

> In that moment I wanted someone to respond empathically and withhold going into my head. I didn't want an intellectual response, I wanted compassion and empathy. I think I needed to be listened to without judgment because my recollection is that the response was something like 'well, you shouldn't feel that way, it wasn't your fault', something to try to minimize or dismiss, or to tell me to feel a different way. I guess I wanted to be listened to more before someone responded in that way. I know intellectually that's an appropriate response. Her death was not my fault. I did the best I could.
>
> I would have also somehow needed to know that I wasn't being a bad counsellor because I couldn't do the school piece. I think I would have felt somehow incompetent, too, if somebody would have come in and taken totally over because I did need to feel like I could do something. I wouldn't have wanted somebody to shut me down and say 'go grieve, we'll do all the work and take over'. I would have felt like a useless idiot. If they would have been with me and taken over the parts that I couldn't do or that they could do with me, I think having someone with me more than taking over would have been helpful for me. I would have felt supported, but also knowing that people believed that I had some competency, and also to acknowledge that I needed to have a role in what was going on in the school, too.

Emily shared many of Anne's ideas about what would have been helpful in her initial grief process. Emily also touched on the importance of supportive debriefing with colleagues after such an incident. At the time she experienced Ryan's death, Emily could not ask for that support. In retrospect, Emily wished the debriefing process had been automatically implemented:

> I didn't need anybody in my face to ask how I was feeling, what I needed at that point was for someone to say, 'are you doing okay?' What was the first thought you thought of right now? Are you able to go home and sleep tonight?' I could have used that, that initial debriefing and diffusing. I think if someone said, 'we're going into this role, you're going to be debriefed, we're going to diffuse the situation'. I probably would have been more willing at that point to be emotional and say 'I'm really having a tough time.' Away from the school, if we would have gone to the board office or another safe place at the end of that day, I probably would have had a grief reaction which I think probably would have

> been extremely healthy. Instead, I went home, had to pick up my kids, cook dinner, and all that kind of stuff.

James felt like he was navigating his experience of loss without any direction. Having a mentor or colleague who could comfort James, sit with him, and help him find his way, would have been invaluable. James commented: "It would have been nice to have somebody to guide me through all of that, but everybody is so busy dealing with their own stuff. I'm not sure that I even presented it other than just mentioning it."

Several participants were able to retrospectively express the kind of support that would have been beneficial during the initial phase of their grief process. Having someone safe who would listen when they needed to talk, who could provide them with some relief and support while they facilitated the schools' healing processes, and who could reassure them that they did everything they could and that they were still good school counsellors, would have been helpful as the participants struggled to make it through their losses.

Standing Alone on Stage

Three participants worked in large well-populated schools, yet they spoke of feeling isolated in the sea of people. School counsellors are the ones who students and staff turn to when they need support. Several participants commented on how isolated they felt, including John who said: "I would imagine the degree, and I don't think anybody would be different in this, in the amount of aloneness you feel about it all." Emily felt alone because she was just starting her grieving process around the same time her teaching colleagues thought people should be putting the experience behind them. While she had a strong support team, the delay in her grief process left her feeling alone. Emily talked about her frustration, saying:

> What happens, especially in the high school, is that . . . out of sight out of mind. Ryan hadn't been in school for months. So for a lot of people, because we have a lot of high-risk kids here, it's like 'he's gone Emily, move on to the next one'.

Anne's response to the lack of support she received was to emotionally shut down. Over time her hurt and disappointment has turned to acceptance. She no longer expected from her colleagues what she knew they could not provide. However, Anne has been profoundly impacted by the isolation. She shared what impact it has had:

> I know that at first it was very painful to have that awareness that I was really isolated from my colleagues. Over time, I don't feel as strongly about it. I guess the pain just isn't as strong. I've reached more of an acceptance and an understanding of what my colleagues are capable of, from my perspective. So I don't expect them to be there emotionally for me. I don't expect that I can discuss cases with them or turn to them for any kind of counselling consultation.

Participants who spoke about isolation typically referred to their sense of being alone in their experiences. Participants did not reach out to their colleagues because they needed to maintain client confidentiality or because they were embarrassed to ask for help. Several participants noted that their colleagues were unaware of how deeply affected they were by their clients' suicides.

Casting New Roles

Six participants had colleagues either at work or in their community who were able to provide some form of support. Fred spoke about the importance of having good professionals in the community available for consultation:

> I'd hate to think that I was the only one working on it. I mean that's what we counsel people to do, to make sure that you're not the last one to talk to someone that commits suicide, basically. That they need to be working with as many people as possible on it because it's not something that I think one person can handle. It's a team effort from home, from medical, from outside counselling agencies, from school, you know, I think it basically has to happen that way for the best interest of the student. We've been very fortunate here. We had a doctor here in town that was just amazing. He had done a lot of training on stress, on suicide, all those types of things. He would take referrals of people, they didn't have to be his patients or anything.

Anne did not feel the emotional support from her colleagues but credited them for taking over the administrative responsibilities while she focused on helping the school community heal from the tragedy. Anne outlined the support she received:

> They all thought that I was handling it and that things were under control. I think people took over and did things for me that I'm not quite aware of. You know, I wasn't doing anything else but this. There were new registrations and there were timetables to change. Somebody must have been doing all that for me because I wasn't doing much of that myself.

Participants were thankful to be supported even if that support was only provided in small doses. Emily was fortunate to be surrounded with a good group of colleagues in her school. She described what that support meant to her:

> I find I have a great support system working right in the high school guidance office because I do have the other guidance counsellors. I work closely with the principal so I feel that I have a good support. I think some of the elementary counsellors that don't have that guidance office space are more at risk for burnout than me just because I do have the support of other people.

Maggie also had the support of her colleagues. As a crisis response team, they debriefed after each student death. Maggie explained how the team operated: "What we have done as a team is we know that we are hurting as well so we make sure that we debrief at the end of every single day. If we need to cry, if we need to lean on each other, we do all of that within." Maggie's team was able to deal with their loss experiences in an insular way so that they could continue presenting their professional exteriors to others while processing their personal losses in private.

Bob relied on the support of many individuals to help him cope with both clients' suicides. While he talked about the support he received from colleagues in general, one individual, in particular, stood out: "The principal that I was working with was an incredible person . . . a wonderful, caring, humanistic kind of individual. He basically was my mentor, my guiding light, my soul, and because of him, I just stayed with it."

John found himself in a position at school where he was doing the majority of the personal counselling. He said that each counsellor in his school had his or her own area of strength and John identified his area of strength as personal counselling. John's colleagues tended to work with students on more academic concerns. However, he indicated that the division of responsibility balanced out his department. When John experienced an emotional situation, such as the death of a client, he felt he could lean on his colleagues without worrying that he was adding to their burden:

> I have to admit that I've never been in a situation where I've had to deal with a suicide in my own school where I did not have other colleagues. It was nice that some of my other colleagues were detached from it so I could say 'you know what, I'm not. I'm not detached from this. I'm having a hard time with this'.

Designing the Set

While participants were aware that some services existed for them to work through their experiences of client suicide, only two participants chose to access those resources. Several participants commented on the barriers to seeking services. Anne, for example, recognized the need to work through what she had experienced in a safe setting with another professional, but was embarrassed to reach out and contact someone in the district. She reported: "nobody knew what to do. I was too embarrassed to phone." Although Fred was aware of the employee assistance program, he did not consider contacting them after he experienced his client's suicide:

> We have an employee assistance program that we could actually go and talk to somebody for emotional, psychological assistance . . .it's part of our contract for employee benefits, but I guess I never even thought of accessing that.

James was so engaged in helping others to heal that he neglected his own process. Further, employee assistance services were not available at the time of James' experience. James hypothesized that if counselling services had been available, he would have accessed them:

> Sometimes we get too busy or involved in other people's problems to deal with our own. I think that's probably the nature of the beast. I think that as counsellors, we don't take our own advice as well as we should. I think it's important to have that process in place.

Two participants who sought services spoke of the therapeutic value in processing their experiences with other mental health professionals. They both indicated that so many people around them needed something from them—reassurance, support, counselling—that having someone there just to help them was critical to their healing process. Bob valued the expertise his counsellor had in the areas of trauma and suicide. After each client suicide, Bob worked with a counsellor to process his experience. Bob said he was "very, very happy to have someone work with me through this." Anne talked about the validation she received from her counsellor:

> I felt that he was really skilled and he supported me in my horror of my colleagues not wanting to do anything. He kind of validated my experience of expecting other things from people that didn't happen. He was really good, and he supported how I was handling everything. He checked out my supports to make sure that I had other people to talk to. He also invited me to come back if I wanted to, and he said that he felt, you know, that of course all of my reactions were normal . . .

Though Fred, John and James did not received counselling to support them in dealing with their losses, they acknowledged the need for counselling resources to be more available. Prior to participating in this study, Fred had not considered providing services for bereaved school counsellors: "no, there's nothing for the caregivers. It makes perfect sense that there should be, but we've just never done that." John, though he did not receive counselling himself, recognized the importance of such services: "I think it's really important, really important that people who are in the caring profession have other people around who can help them". James reflected on what it would have meant for him if that support had been readily available:

> You know, to be honest with you, I don't think there's enough care for caregivers. I believe that I could have used another counsellor from one of the other schools to come talk to me. I could have used our district psychologist to come and talk to me. I was too in shock, myself, to initiate that.

Ironically participants in this study had not given considerable thought to the needs of bereaved school counsellors. They eagerly provided care for students, clients, family members, and staff, yet these school counsellors disregarded their own emotional needs. In retrospect, most indicated that they would have accepted services had they been offered or readily accessible.

Revising the Script

Participants reflected on their work with their clients, which caused them to think about what they could have done differently or how they may have intervened in their clients' decisions to commit suicide. This reflective 'what if' process was significant for participants. The following excerpts illustrate how quickly the participants questioned and, at times, second-guessed their treatment strategies:

Anne: I tried to think about why I didn't ask her. Was there something about . . . that she said to me that I missed. . . why didn't I ask her? The only thing that I could think of was that there was nothing that she told me that made me think she was suicidal.

Fred: Yeah, I mean, that's very tough. It makes you reflect and say, 'what did I miss? What happened? Was there something else I should have been doing?' You start questioning all of those types of things.

James: I grieved . . . every time I'd look at, or run across her letters or the yearbook, it would cause me grief. I would get that hollow feeling in my gut and always wonder what I could have done differently. In suicide, that's the biggest question for everybody, you know, 'where did we go wrong?' You tend to blame yourself.

Maggie: Well, you start to think, 'what could I have done differently', 'what should I have done', 'why didn't I see any of the clues'. Not necessarily blame. I will never take the blame for someone committing suicide.

John: I guess in knowing the boy and knowing his mother, I thought 'why didn't she tell me or why didn't he tell me or why didn't I pick up on something' and . . . I guess maybe, 'did I not spend enough time, did I not look for things, was I not open enough?'

Bob: I try to calm myself down. I try deal with the uncertainty. I spent many years trying to figure out if I caused his death.

Participants logically knew they did not cause, nor could they prevent, their clients' suicides. Yet, six participant engaged in some sort of reflective 'what if?' process. The desire to understand what happened ensnared participants in the destructive web of self-doubt. Fortunately participants reached a point where they recognized they were not responsible for their clients' choices.

Participants talked about their reflective practice and were able to articulate the key aspects of their experiences that affected their personal and professional lives. John found that some positive lessons arose from his loss. He brought what he learned home: "So you see what happens and you try to learn from it and bring it home and make things as best as you possibly can for your own children".

Participants integrated what they learned from their losses into their professional practice. For instance, Bob did not shy away from working with suicidal clients and in some ways became more closely connected to those clients by being fully present with them as they endured the isolation that accompanies suicidal ideation. He talked about the lesson he learned from his first experience with client suicide:

> So from her, I learned a life experience that I still practice to this day. That when an adolescent shares this with you, there is no such thing as confidentiality. So you asked how it changed me? The sensors were long and acute for dealing with this. And in some ways I think that it made me a more empathic listener.

Emily focused her attention on the clients she may have previously overlooked. She talked about recognizing the needs of those clients who did not voice their concerns. Emily spoke about her new focus: "I just want to be very careful of the quiet ones. Even if they're not giving out direct information about their mental state, that there are other clues."

James' voice became stronger as his confidence in his own clinical judgment increased. He no longer settled for having his concerns overlooked by external agencies. James realized that he needed to keep talking to the people who had the power to help his clients until he was heard. He described his learning:

> it's about the squeaky wheel, you've got to be heard. I learned from that situation how to play the game better politically. As a counsellor, I hate the politics. Politics is a horrendous thing. Sometimes when you're being an advocate for a child, you have to be good at playing the game. From that, I learned a lot about how to play the game.

Fred integrated his experience of client suicide and his previous experience of working with an adolescent who attempted suicide into his classroom. As a counsellor educator, Fred was able to share with novice counsellors information about what no counsellor wants to endure—client suicide. He also spoke of the insight he gained: "If anything, it's probably given me a little more confidence, a little better understanding of the job. And, I know that I certainly try to relate that to others when we're talking about it." Maggie found that her professional contact with clients' families after their children's suicides helped her personally. Maggie stated: "I find that it helps me personally because just being able to connect with the family and to experience what they're going through. It makes a connection for me that is very . . . how can I say it . . . almost peaceful. It brings peace to me."

Bob worked with many professional counsellors over the years and part of his healing has involved sharing his story with others. When he told his story to other practitioners, Bob spoke of the powerful lesson he learned about accessing resources for his clients:

> I still have a hard time saying it, but 'here's a mistake I made and the mistake was I placed too much credence in the trust where I should have done what I basically did with

> the subsequent students that had shared with me this. I should have accessed the resources immediately'.

Anne incorporated what she discovered about boundaries and self-care through her experience of client suicide into her professional practice. If she were to maintain her own well-being, Anne realized that she could not service the entire student body. She always made time for the clients on her caseload even if that meant staying at work longer but she limited the clients she saw to those who were on her caseload. Anne explained:

> I say 'no' more than I used to if they're kids that are not ** (part of caseload) because my caseload is way more than I can handle as it is. In order to serve those kids in the way that I think I need to serve them, I had to say to myself 'these other ** (colleagues), it's not my fault that they can't do they're jobs properly'. If there's a kid at my door that wants to see me, I see them. Even if I'm up to my eyeballs in paperwork or I've got nine thousand other things I'm supposed to be doing that aren't as important, I see the kid. What that means is that I stay later after work doing the other things that my colleagues shut their door and do.

Participants focused not only on their experiences of loss but also on what they could learn from their experiences. They were able to incorporate these lessons into their personal lives and their work with clients.

Performing Again

Working with suicidal clients is not a one-time career event. School counsellors who participated in this study continued to counsel suicidal clients after having experienced their client losses. Participants' experiences informed their work with suicidal clients that came after. Maggie summarized many of the participants' sentiments when she said: "So I think with each case I have, I am wanting to prevent, even more than the last one, because I know the devastation that it can cause."

Anne spoke about the first client with suicidal ideation she counselled after her experience of client suicide. She needed the support of district colleagues and was thankful when that support was provided. Anne recalled: "Everybody acknowledged that it was a really difficult situation . . . and they didn't abandon me. They really hung in there and that was really cool." Similarly, Emily spoke about her fears and the support she received from her colleagues:

> I'm sure there was a little part of me that didn't want to deal with another suicidal death. I think with the debriefing and the diffusing and putting something more in place, I think we've learned a lot from this experience in the sense that we do need to be able to lean on each other.

Bob's strategy changed as he became more proactive when working with suicidal clients. He involved supportive professionals in the process immediately, widening and strengthening his clients' safety nets:

> I'm not saying that I messed around the first time, but the first time I just placed too much trust in the relationship. This time I was going to act because as soon as I heard the word suicide it was like all the bells and whistles went off again and I wanted to be proactive. I wanted to be preventive.

Like Bob, John became more proactive when working with suicidal clients. Despite his initial fear, John focused on protecting his clients. As his focus sharpened, all of his knowledge, skills, and confidence returned. John narrated his internal dialogue:

> And then it's 'okay, they have picked me, they have chosen me. I have been granted the opportunity to make a difference. Okay. Don't drop the ball here'. Then it's 'okay, put on your game face, go through this slowly, be clear, listen well'. You know, all those things you tell yourself. 'Don't freak out, don't freak out'.

When asked how they continued to work with suicidal clients, six participants were able to share a variety of skills, abilities, and knowledge that helped them to develop confidence in continuing to work with this population. Each participant also spoke about accessing support services more quickly for their clients and involving as many outside people as necessary to maintain their clients' safety. The following excerpts illustrate how participants asked the tough questions, accessed resources, involved consultants, and implemented plans:

Anne: I didn't call other people in all the time whereas now I'm more quick to . . . even if there's the slightest possibility the kid has suicidal ideation. Even if they're low risk I call the suicide prevention people and have them come in, and I call the parents. I'm more quick to ask kids if they're thinking of killing themselves rather than waiting for them to tell me they're thinking of that.

Bob: I became a lot more sensitive, a lot more acute and when . . . there were two more situations where students had basically shared with me their thoughts of suicide . . . this time there was no sitting back. As soon as this was shared with me, I said to the students 'I appreciate the confidence in me, but I must now do something with this because your safety, your life, your wellness is so important to me that I've got to bring other professionals into this'.

James: I think in dealing with suicide, you just can't take chances. In another year where we had a number of suicide attempts, we got them the help they needed right now, right then. We did not take 'no' for an answer. The other thing I got to learn from all of this is that in counselling, intuition is so important.

John: I would say probably at first it made me more panicky. After a while, it's kind of counterproductive to live in fear. So I guess I just decided to try to be more attuned to what people were presenting me. Not in every case, but in a lot of

> cases there was something there. Which, of course, now as I'm saying that I'm thinking maybe I'm not doing a very good job at this anymore. I don't know. It did make me probably even more resolved to take a firmer approach in some cases than I may have.

> Emily: The ones who come in and you know they're full of rage and they say, 'I don't want to talk about my family'. I think it's taught me to make sure that you continually strive to be even more clever. Even if they're not giving out direct information about their mental state, that there are other clues.

> Maggie: Now that I know what I've gone through with clients that have committed suicide, I now try to bring in a much more personal, closer to home, level so that they can in their mind think that 'oh my God, my mother would be absolutely devastated'. And if that can be part of the reason that prevents them from doing it, then that's what I try to do.

Certainly participants experienced loss with the deaths of their clients; however, they also gained the gift of experience. Participants used their experiences to better prepare themselves to work with suicidal clients. As the confidence in their clinical judgment increased, they became comfortable activating more aggressive protection measures for their clients.

Interpreting the Dance

The theme *Interpreting the Dance* underscores the importance of processing the personal and emotional experience of client suicide. Counsellors embarked on their own healing journey. While they took different paths, participants came to a place of acknowledgement where they accepted the personal impact of their losses. Participants were able to use elements of their experiences for constructive purposes, while at the same time recognizing the destructive essence inherent in client suicide. Their grief experiences varied depending on their personal and professional circumstances as some participants were not in a position to have supportive colleagues surround them, while others were able to reach out and receive the help they needed.

Finding a Partner

Participants spoke about the importance of having at least one person with whom they could confide. Even if participants did not fully share their experiences of client suicide with their support people, it was helpful to have that general support. For Bob, the pain was so intense that his only option was to reach out for support. People around him knew that Bob needed some assistance in navigating through his loss experience and they provided him with the necessary direction. Bob talked about the importance of friend, family, and colleague support:

> So to work with another professional . . .he [mental health professional] gave me . . . and the staff, and my principal, and my friends, I have to mention my friends, they gave me

> the stability I needed to work through this. Because of them I was able to . . . I came through this. I didn't collapse, I didn't fall back, I didn't revert to alcohol, I didn't revert to drugs, I didn't contemplate suicide myself. I realized that I had to keep going, but when I was crawling on my knees I was able to get up off the ground and keep going, which I did.

Unfortunately Anne was not able to have her support needs met within the school setting. She sought solace in friends and colleagues outside her school because she knew she needed help. Anne spoke with great affection for the friendships that sustained her:

> Well, this friend of mine in ** (place) was really good. She's just a gem. I called her several times . . . and I've got another friend that I'm really close to as well. I talked with her. So they were really important supports for me during that time.

Other participants, too, reinforced how meaningful it was to reach out and have people listen to their stories and offer support:

James: I had a fiancé and I had one roommate so they gave me whatever support they could.

Emily: We [Emily and her husband] would be driving and the song [that reminded her of Ryan] would come on and we would just have moments when that song came on. It was our remembrance. I think little moments like that through the way really helped.

Fred: . . . through a lot of talking with my wife. That's my biggest support. She's a very good counsellor, listener. We share a lot of our feelings and can express them.

John: . . . certainly talking with my wife is very important.

Maggie: Well certainly I do have a very strong network of colleagues that I can share with, and my staff are very supportive and are always asking me how I'm doing when we're going through this process.

Participants talked about the different ways they reached out. They reached out to people they trusted, professionals, family and friends, to hold them up when they did not feel they had the strength to do it on their own.

Sensing the Rhythm

Some participants discussed their need to resolve their inner turmoil. This resolution was accomplished in a number of ways. For instance, James quit playing the 'what if' game and accepted that Trish was responsible for the decision she made to end her life. He also focused on what he could learn from his experience and on the positive systemic changes that were implemented after his client's death:

> I accepted the fact that Trish was going to take her life no matter what because she was at the point where she, herself, believed that she had no reason to live. I quit second-guessing myself about the contracting.
>
> I think that as a caregiver, it's very, very important to remember that out of every negative situation there are positives that can come out of it. I think it's important to pass that on to clients, too. Suicide is the most negative situation that can happen and unfortunately the positives that came out of it is that, you know, ** (hospital) made changes for the safety as their clients there because it wasn't as safe as it could be.

Fred worked through a similar process in which he was able to remember and honor the life his client led without glamorizing or normalizing the act of suicide. He came to a place where he did not focus on the death but rather on his client's life:

> It was probably good for me, in hindsight, to work through it and say 'this is what we did'. These are all the things he was good at in school' and looking at the positive things. And, of course, one of my concerns is the whole copycat thing around school and not glorifying the death. Remembering the person, but saying, 'maybe not a good choice to end it'. But still being very respectful.

Bob was able to see the gifts his clients presented him. Harvey brought Bob closer to his faith: "Harvey in some ways is a gift to me. There are times, there many times when I thank Harvey. And I do talk to Harvey. I ask him sometimes not to scare me." Bob's other client taught him about his own humanity: "I had to provide her a sense of comfort, a sense of peace, that's why I held her in my arms . . . so that she could die at least warm, at least with a pair of arms around her, so that she knew that somebody cared."

Emily struggled with her belief that Ryan's act of suicide may have been his escape. Dying ended the agony Ryan endured in his life. Though saddened by his choice, Emily was able to imagine what he must have been going through to make such a final decision:

> It's hard for me because I'm not one who likes to judge when people decide to do what they need to do with their own life, but I don't like to say that suicide is an answer at all. But I honestly feel deep down that Ryan's life would have continually been really horrific. So I pray that he's in a better place right now because I think the stuff that was going on in his home . . . no matter if he got out when he was eighteen or lived on his own at twenty-one, I don't think the things that happened to him, that he would have ever felt normal. I think the shame would have been carried with him for a long time and I think he would have started hurting other people. I'm glad for him that when he died, that he never really truly hurt anybody else.

John talked about the need to put his loss behind him and move forward. He was careful not to imply that moving forward meant ignoring what he experienced. John spoke about acceptance: "If acceptance is that it's done and there's nothing that I can do about it now and I've got to move on with my life and live to fight another day, then yes."

The choice to either move on or to stay in the sadness was not always left to participants. Two were interviewed during the course of their clients' suicide investigations and were forced to recall on command aspects of their therapeutic relationships and details about their clients.

James: What did impact me was every time I would go through something and I would find a letter that Trish had sent me and everything would rush back. Any time they'd come back and interview me in regards to her death, that also would bring everything back. Every time the memory would come back, it would leave me with a huge empty feeling that would last for hours. It was just a huge empty feeling in the pit of my stomach. So it was about a year and a half or two years before I was able to deal with that, let it go, and move forward.

Emily: The poor guy, when he came in, he had been on the investigation since ** (day of the week). He was just a mess. He looked so tired (. . .) Instead of really asking me questions about Ryan, he sat and vented for an hour and a half for what he had been through, which is very normal for other professionals to come and discuss what had happened.

Finding ways to make peace with the decision their clients made enabled these participants to move forward. Moving on meant integrating the lessons learned, not forgetting what they, or their clients, went through.

Staying in the Moment

Three participants talked about the overwhelming feelings that washed over them. While they worked hard to move forward, they would often be swept back into the center of their loss. Just by talking about his client James felt the rush of emotion: "It just brings back so many overwhelming feelings and it is a heavy, heavy thing you're dealing with." He talked about the person this world lost in his client's act of suicide: "Trish was an amazing athlete, individual, person with tremendous unlimited potential that had her life taken from her because of horrendous circumstances, you know?" At some point in his healing James decided to take control of his emotions and create some closure so that he could focus more on the here and now. He accomplished that goal by turning inward and creating an appropriate ritual to both celebrate her life and to let the memory of her death go:

> It was hugely emotional. It was such an amazing release. In order to do that and to come to that conclusion, I had to separate myself and counsel myself. That's a really difficult thing to do as a counsellor. It's easy to give other people advice, give them suggestions, and help guide them. But, it's really hard when you're under emotional stress to do that yourself.

Emily shared her experience of having emotions wash over her at different times. She was aware of many of her emotional triggers and chose to experience those feelings rather than to suppress what was trying to come through: "I think it's come at different times. I think one day I was driving home and I live near the school where James attended which sometimes triggered it." Bob still visits his first client's grave when he is in town: "I still go back. When I go back to the city and visit, there are times when I still go there and she has a lovely . . . what is it a headstone? I'll often go back and I'll talk with her . . . it's all I can do." James, Emily and Bob allowed themselves to experience the emotions as they came.

Feeling the Final Song

Funerals are a societal ritual for the purpose of remembering, mourning, connecting with others, and tapping into spirituality. Anne was the only participant who did not attend her client's funeral, as she did not know about the death until some time after the service. Some participants found the funeral provided very cathartic experiences, particularly for those who were involved either in the organization of, or participation in, the funeral service. The following excerpts outline the positive elements these participants experienced by attending their clients' funerals:

Fred: I'm not . . . I'm very emotional and I could not usually be able to do that kind of thing. I think the whole process of creating the eulogy was probably good for me in the fact that it was the reflection that I needed to go through the process.

Maggie: Because I do go to all of the funerals of my clients that do commit suicide and that's where I do my grieving. Yeah, it's right at the funeral. I bring lots of kleenex. Now that I think about it, maybe that's where I give myself permission to because it's allowed right? I've gotten to the point where I can remove myself from taking home personal things. Obviously the devastation of a suicide I will take home and think about, but I've never done any crying or sit there and do really tough grieving at home. Pretty much I keep it all inside and when I go to that funeral, that's when I let it go. I didn't know that before. That's what I do.

John: Not that I'm going to be there crying and wailing necessarily, though I'd be lying if I said that I never cried and cried in public in some of these situations. I certainly have at some of the funerals I've gone to, though once again not with every student as I wasn't always as involved with the students. But in the two cases where I had more involvement, certainly I did in both cases. Plus, I feel good if I can help in any way, shape, or form afterwards. Maybe that's to make up for the deficiencies that I worry about having in the first place. Maybe it's just trying to play catch-up.

Emily viewed the funeral as another work venue because she was there to care for Ryan's friends during the service: "We brought extra people that were not going in the funeral home that stood outside and supported the kids outside at that point. My husband joined me and the principal from the other school and some of the kids sat with us." Emily also talked about the frustration she felt knowing Ryan's family members were there grieving, yet they were responsible for the abuse he endured in life: "The family was grieving all over the place. They were crying and sobbing saying 'poor Ryan'. It was just very hard because there was just so much crap that they did to this boy."

Like Emily, at his first client's funeral Bob came face to face with the person he harbored resentment for. Bob described that encounter:

> I remember at the funeral and I had walked up . . . the big honcho psychiatrist was there from the hospital . . . and I walked up to him and I said, I don't know maybe he should have punched my head in, but I said 'yeah, she's fine isn't she? Maybe next time you'll listen to a lowly school counsellor' I said 'because you have no idea how angry I am with you right now' and he just walked away from me.

In contrast to participants who had cathartic experiences at the funeral, James found the funeral to be more destructive than constructive. While he noted that funerals can be a place of healing under circumstances of accidental or natural death, he stated that funerals for those who have committed suicide are not healthy places to grieve: "But in suicide, funerals are very, very negative and they don't provide the relief that other funerals do." James suggested that funerals for those who committed suicide are unhealthy because there are too many complicated emotions coupled with unanswered questions.

Staying in the Game

The final theme *Staying in the Game* represents the hopefulness expressed by each participant. Despite losing clients to suicide, participants ultimately chose to continue counselling in the school system where they had no other option than to continue working with high-risk suicidal youth. Some even embraced the opportunity to work with that high-demand population as they believed their personal loss helped them grow professionally. Therefore, the theme *Staying in the Game* signifies the participants' progression, personally and professionally, post client suicide. Their stories did not end with the suicide; the suicides merely punctuated their continuing journeys. It has been decades for some participants since they experienced their clients' suicides. For others the wounds are fairly fresh.

Retiring the Jerseys

Participants recognized the lasting implications of their clients' suicides. Bob vividly remembers how two adolescents died. His journey continues in his daily life and also in his dreams, his relationships, and his faith. Bob knows how his experiences have been etched into his being: "as I look back in some ways, I think it led to the breakup of my marriage. As my wife told me years later, that incident basically changed me in terms of what she married and what I became was in essence two different people." Not only did his marriage come to an end, so did his restful nights. Bob continues to endure symptoms that many people who have been traumatized experience—recurring nightmares and flashbacks:

> I was having a difficult time sleeping. I have incredible nightmares. To this day, at night time, it's like his face exploded and all I remember was blood and remnants . . . it was like someone flung it on me and it was, God, it was the loudest bang. The next thing I know, I had someone grabbing me and I was being pulled out of the room. I don't know what happened. To this day I still don't know what happened. This one I don't forget. In the flash, I see the head, I see the blood, and it basically snaps me awake. And by that time I'm usually sweating like a pig and then I'm up.

Bob knows that even with the therapy and support he has received, he will not forget what he has experienced. He has, for the most part, accepted that these two adolescents will be with him for the rest of his life: "I'm going to live with Harvey the rest of my life because what happened . . . both of these children, their deaths were traumatic in themselves."

Emily realized that the lack of proper debriefing after her client's suicide made the healing process more difficult. She was very aware of how inadequate debriefing may have further complicated her bereavement experience: "What the counsellors said when we were going through this process was that they felt I wasn't debriefed properly. That was something that probably psychologically affected me for a long time." James has worked hard to move on but admitted that talking about his client still brings up raw emotion. When asked how he was doing after each interview, James said:

> The first interview was much more difficult than this interview, but before it would take me quite a while to feel like I could hit my stride again. This time, it didn't stay with me very long.

John articulated his understanding of the difference between dealing with the crisis and living with the after effects, which was something other participants commented on as well. John was clear that the experience of losing a client to suicide does not end when the concern at school has decreased or when classes have returned to normal schedules: "one of the problems is that you go in and you deal with the immediate situation and the people around you at some point say 'well, thank God that's over with now'. And yet you know that it's not and it never will be in a way." Recovering from client suicide is a long, involved process.

Warming up

Participants talked about how they take care of themselves so they can continue to work effectively, parent well, or engage meaningfully with others. For two participants the idea of self-preservation became vitally important after their loss experiences. They developed strategies to set boundaries emotionally and environmentally. Maggie, for example, developed several ways to emotionally disconnect after working through multiple client suicides:

> Maybe it's one of those things that happened naturally for me for self-preservation. I didn't say to myself, because when I was a lot younger and I would hear about suicide, it would affect me and it would be very difficult to work through. As I got older, I didn't allow that to happen.

When Anne was confronted with year-end staff changes she decided that if a new counselling staff member increased her stress level, she would explore other career possibilities: "If it's someone else who I'm not going to be able to connect with or who's going to add to my stress-load, I can't do it anymore. It's just too much." Anne said that decision would not be based solely on the experiences surrounding her client's suicide; however, it would certainly be a factor in her decision.

Participants spoke about the different ways they incorporate self-care into their lives. Regardless of the demands placed on them at work or home, self-care remained important. Anne, John and Maggie talked about their mental wellness:

Anne: I take care of myself and take quiet time for myself. I do all of the things that I know I'm supposed to do to look after myself. I have a therapist that I've seen on and off over the years. I haven't seen her for a couple of years, but I know she's there in case I ever need to go back and see her. I'm not hesitant to get help if I need help. I see my doctor if I need to.

John: I can't imagine dealing with these things and having a whole raft of personal problems that I'm working on at the same time.

Maggie: I'm a strong believer in physiotherapy. I don't get headaches, but I get tension in my neck. So what I'll do is book an appointment with my physiotherapist for a neck massage to release the tension.

Maggie, Fred, and Anne spoke about how they maintain healthy lifestyles. Maggie talked about being centered in both mind and body:

> It's rest, it's eating properly, it's exercising. If I'm going through a week, because typically it can be a whole week from beginning to end of dealing with a suicide, I make sure that I get my exercise. Even if I just get out there and just walk. Just become one with nature is what I try to do to clear my head, and look around and look at the beauty of the world to take my mind off the ugliness of suicide.

Fred identified physical release of stress and tension as an important element of wellness: "Exercise is always a good way to get your mind off it. I do enjoy being out and doing things."

Anne discussed the idea of balance in a healthy lifestyle: "I basically have a really healthy lifestyle. I eat well, I exercise sporadically, . . . I have a healthy life."

Five participants said their spiritually refueled or maintained their strength and enabled them to do their much-needed work. For some, the experience of client suicide brought them back to their faith. For others, spirituality had been a resource often utilized throughout their lives:

Bob:	God has been there for me. I think I am who I am today, as a practitioner as a person, because of His strength. So He's a part of my life and He wasn't that big a part of my life . . . I had moved away from being raised a Catholic and I had moved away from the Catholic Church and my faith was really on the rocks.
Fred:	If it's a very difficult personal situation, I do have a spiritual connection that I would rely on.
Anne:	One of my personal supports is prayer and a spiritual community where we are all working on our spiritual growth.
Emily:	I think some part of it was peaceful, just knowing that I'm glad he's [Ryan's] not living with those people anymore. I do believe in God, I do believe in heaven, so I'm hoping that's where he is.
James:	I'm not a religious person. I don't believe too much in organized religion, but I do believe in spirituality. So, I think the spiritual side was very, very important to me.

Developing New Plays

School counsellors typically do not talk about the work they do in schools because they need to protect client confidentiality. Therefore, administrators and district officials are not always aware of the important work being done. In times of educational cutbacks, counselling services in schools are often scaled back. Thus, the role of the school counsellor has changed in the recent past. John talked about the impact of cutbacks at his school:

> Our principal has already had to say that the personal counselling stuff is going to have to go by the wayside and we'll be working on timetable changes and the nuts and bolts of the school as opposed to doing any personal counselling. And the personal counselling is what I really like. But, it is what it is. It not just me, other departments have been hit hard too. I don't want to make it sound like 'woe is me' but we're in a pretty dire straight.

Maggie commented on the increased workload community agencies have been handed over the years. She acknowledged that schools are not the only institutions that have been hit by cutbacks. As an experienced counsellor, she also said she is less reliant on outside support:

> I'm finding that outside agencies have huge caseloads as well, so it often takes time to get them in to see someone. And, because I've been in this business for [a number] of years, I do make less referrals than I did when I first started out.

Anne reported one of the main changes she has experienced in recent years: "I'm finding that we don't have as many resources in the community as we used to." Fred talked about reduced counselling staff to meet the needs of more students: "As the head of the guidance department, that has changed over the last few years because of the government's funding and cutbacks. We used to have four counsellors in here and now we're down to one and a half." Emily commented on the changes that she has seen in clients' presenting issues: "We are dealing with a lot of mental health issues that really don't necessarily fit our mandate. The referral system is really poor right now so we are dealing with a lot of mental health issues-depression, anxiety, and various crisis situations." James talked about a positive change he has seen take place in his school district. When James had his experience with client suicide there were no postvention protocols in place. That has changed in recent years: "We have in the district that I'm in right now, if there's a death of a teacher or a death of a student in the school, we have an emergency response team and they're there to help teachers and help students, to help them through the whole process."

School counselling in the twenty-first century is vastly different than school counselling of the past. Participants touched on a number of areas that have changed in recent years including counsellor-client ratios, mental heath presenting concerns, and postvention protocols.

Holding their Positions

Most participants shared their reasons for continuing to work in the fast-paced environment of a school setting. Instead of hiding from their experiences, these participants face daily what created so much pain. Bob readily admitted that he has faced a lot of challenges in his lifetime. He said that he physically shows some of the weathering he has experienced, which makes him more human in the eyes of the clients. Bob recognized: "I tend to attract them, or they tend to come to me, and that's okay. That's okay. It will be like that until the day I retire." He has integrated those experiences into who he is and how he interacts with others. Bob acknowledged: "How can you take a life experience like I've gone through and not make me, in some ways, a better person? But it took a long, long time to work myself through that."

Like Bob, James believes that he has transformed his loss into something powerful, something that has enhanced his ability to do his job. James stated: "I think it's really hard to take positives out of a negative like that, but the fact that I was able to move forward and not let it eat away at me I think it made me a stronger person and a stronger counsellor." In order to stay strong, Maggie has discovered ways to separate herself from the choices her clients make. She knows that if she is to continue her work she cannot take on the responsibility for her clients' well-being: "I've now come to realize that their feelings lead them there and so I no longer take ownership of that. It is their decision. They have made that decision to end their world."

At the time of this study, participants were still practicing as school counsellors. Therefore, it was evident that something was keeping them in their school environments. Five participants indicated that they have stayed in their jobs because of the children and adolescents with whom they work:

Anne:	I really get a lot of satisfaction from working with the kids. I really feel like I make a difference every day with kids and I enjoy them. It really feels good to be able to do the work that I can with the kids.
James:	First of all, the love of the kids. I think working with the kids one-on-one was a huge part of what I was about. To this day, I still think the kids see that in me.
Bob:	Some of these kids I've been to their weddings. There's nothing more honorable or respectful than earning the trust and the respect and admiration of young people.
John:	I believe that I can make a difference. And I believe that somebody should try and make a difference.
Emily:	The kids have a pretty warm relationship with me so they'll come up in the hallways and say "Ms., I need to be on your schedule today', you know, 'I need to see you'.

Despite the trials and heartbreaks, these counsellors continue to face their fears, work hard, and confront the real issues head on with their clients.

Coaching New Players

Even though postvention for counsellors in not commonly addressed in training facilities, participants found ways to use their experiences to support new counsellors in the field. Bob has been involved in developing suicide awareness and prevention curriculum and speaks with counsellors about his experiences: "I mean, imagine sharing with other counsellors this personal story. I was not there to sensationalize it, I mean first of all there's no point in doing that. I was there to say 'look, this is what happened to me and I pray to God it doesn't happen to you'" Fred also shares his experience of client suicide with the university students he teachers: "I know that I certainly try to relate that to others when we're talking about it, you know, if I do a workshop. I include some if it in the courses that I teach for teachers [training to become school counsellors] as well."

Like Bob, Maggie and James were both involved in developing curriculum on crisis response for their school districts. Maggie described her role in that process: "Initially there was no protocol in place for that. I've been involved with the team that developed all of that. We've also had in-servicing. We've brought in specialists who are crisis responders who respond to airplane crashes or major car accidents." James found his work on curriculum development to be a healing experience:

> I sat on the committee that developed that plan for the district. It had never been in place prior to that. The next year, I wrote the binder for that. I think it's very, very important because prior to that there were no guidelines or direction in how to deal with something like that. It was very healing for me to be a part of that committee though.

Several participants chose to become involved with their districts' crisis response teams so they could support fellow counsellors in times of crisis. Emily described her involvement: "We have a strong crisis team in each school and we have crisis teams within our ** (organization). We've also been trained in Critical Incident Stress Management so other counsellors who aren't involved in the crisis can fit into those roles." Similarly, Maggie serves on two crisis teams: "I am on our [school] crisis response team. I'm also with our divisional crisis response team, so I've responded to other schools where I've been called in to kind of parachute in and assist." John described how he became involved with his districts' crisis team:

> I happened to know one of the other counsellors in the high school in that community. She said, I want John on the team, I want him to be there. At that time we had a person in the division office who oversaw all the guidance counsellors. He said, 'okay, if that's going to make you comfortable to have him on the team, then we'll put him on the team'. And, I guess they kind of liked what I did because they always put me on team, everything after that I was always called.

After experiencing client suicide, participants worked on curriculum development, crisis response teams, and public awareness to share their knowledge with others. Participating in this study was another way participants sought to share their experiences with other people in the field.

Coming Full Circle

As part of the research process, participants were invited to read chapter four and comment in writing on the chapter itself and/or on their experience of reading what other school counsellors, who had also lost clients to suicide, experienced. They were informed that the responses would be included at the end of this chapter. Five participants accepted the invitation and emailed or mailed me the following post-participation responses after reading chapter four:

James:

Wow, reading the comments of the other counsellors, gave me a great sense of catharsis. I was really surprised to see the common elements throughout Chapter 4. When you undergo something as traumatic as a suicide, you tend to isolate your feelings. To see that others felt the same way or experienced similar things was somewhat of a revelation. When reading Chapter 4 I found myself wishing that we did not have to protect confidentiality as much as we did. There was so much more that could have been said if we had been able to lay everything on the table. Right now I am working with a student who has had two suicide attempts. I have had him hospitalized, and I have a spot for him in a residential treatment facility. Trish's suicide made me stronger and made me a better and more decisive counsellor. I see that reflected in the present case I am working on.

Bob:

It's quiet in the house right now, my kids have gone to bed early and my wife is reading in the living room. I've just finished reading your manuscript and I'm sitting in the back sunroom listening to the rain and in total reflection of what I've just read. A time to reflect and re-internalize some very powerful moments in my life. I have just finished four months of intensive therapy because I wanted to invoke closure (as much as I could) and to achieve peace and calm. It seems that assisting you in this project opened some old wounds that I thought had been effectively dealt with.

Feeling really good right now and look forward to retirement in 1.5 years. I'm proud to call myself a school counsellor and have enjoyed the helping/learning process in a reciprocal manner. The greatest resource we have on earth is children and to feel that I have had an influence on their life is indeed a privilege and humbling.

Emily:

After reading chapter four, I realized that everyone deals with death and suicide differently. I cried for some of the counsellors as I read their stories and how they are forever changed. It was interesting that each story was unique but in some ways very similar. For myself and the condition of my client was in I feared for his future and was so angry about his past and present and how he struggled. Dealing with the loss of someone you love through suicide leaves so many unanswered questions. We all ask ourselves why? Most time we get answers about death such as old age, illness, car crash etc. Even though this may anger us we come to understand why. When we lose a client to suicide we may know what lead up to it but we ask, why that day?

Why that moment? Why didn't they seek us out one last time? I learned that the signs of suicide we have been taught such as they will give away their possessions, leave a note etc. do not ring true. You have to dig deeper to see the signs.

Through out this research project I have felt closer to my client and resolved some of the guilt and frustration. I believe he is on his journey to achieve peace. I know he was angry at me for saying anything negative about his family, and I did suffer some guilt being so open with you at times during our discussions. However the process was healing for me. I needed to share it with someone. Thank you for allowing us to read chapter 4. It was an important part of the healing process for me. I really learned so much from others.

The anniversary of his death is at the end of February and I do feel more at peace that I did last year. Thank you for the opportunity to allow me a venue to share my pain and assist me with the healing and letting go. I realize now to honour his memory I need to respect his last wish. The last conversation we had before his death he had asked that when we talk that I did not discuss his family and their problems. He was loyal to them. I will now respect his wish and speak about his death only as a young boy who left too soon to start a new journey elsewhere. I will continue to miss him always.

Anne:

My eagerness to devour every word caught me by surprise. I really wanted to know what the others had experienced. My desire to not feel alone, to know others reacted the same and had similar experienced in their settings was strong. I was not disappointed. Overall I felt relief and a fellowship with the others. The similarities were remarkable and reassuring. I was moved by the others' experiences and felt a great deal of compassion. The horrific circumstances of some of the stories reinforced my resolve to take action sooner rather than later and to be really persistent in demanding support . . . . and to realized that even if I did this there is so much that is beyond my control. I wanted to give this chapter to my administrators and staff at Student Services but thought I'd better hold off and think about how much I wanted to expose myself and to whom! I did email it to one of my supportive counsellor friends to read. Some of the shared specifics that I found interesting and notable were:

1) isolation
2) a common motivator for all of us to stay in the work is the meaningful connection with the kids
3) being discounted or devalued as a school counsellor is something I have experienced too

4) our initial reaction to the news of the students death (both emotional and physical)
5) diminished and limited outside resources across the country

It was helpful to hear that funerals are not necessarily a healthy experience in the processing of a suicide. It was also helpful to hear Maggie say that she wouldn't put up anymore with unsupportive colleagues.

I would have added that the experience of my student's suicide, and all the aftermath, also contributed to my desire and willingness to develop my spiritual connection further. I have become aware lately that some of the colleagues (and friends and family) have no idea the impact that this event had on me and also that they do not know what I do in my job. I have become much more vocal whenever I get the chance to let people know what my daily experience is like in my job. They are shocked.

The identification of the themes was very helpful. You were able to explain my reactions with these themes and that really helped me to make more sense of my responses. I was very glad I had participated in the study.

John:

Upon reflection and in response it was very enlightening and interesting to both participate in the study and to see the comments of both myself and my anonymous colleagues. I had not had a chance to really reflect on my experience in dealing with the student suicides I was involved with. As well, I didn't really have many other people's views regarding their experiences in similar situations. I found this to be very helpful, interesting and in some cases comforting. I guess I think that it should be standard protocol to have something in place to help care-givers who experience such things. It broke my heart to read about the pain and loss that some of the other participants suffered. It made me grateful for all the support that I do have. It is a difficult role that many of these participants have taken on, and it is a shame that many of them seem to be lacking in the support that they needed.

CHAPTER FIVE

DISCUSSION

The purpose of this qualitative study was to explore the experiences of school counsellors who had lost clients to suicide. Perspectives elucidated are unique to the participants whose particular experiences were expressed. However unique, the richness within these experiences, presented through themes, is reflected to some extent in the literature. While the literature fails to capture the complexity of each participant's experience, it serves to support many elements of the themes.

The participants' experiences of client suicide were represented in this study through four themes: *Taming the Control Beast; Wearing the Mask; Interpreting the Dance; Staying in the Game*. These themes can be connected to existing research literature on mental health professionals' experiences of client suicide. School counsellors' experiences, though, have not been specifically represented in that body of literature. Therefore, some elements within these themes are unique to the discipline of school counselling.

Taming the Control Beast

The first theme focused on school counsellors' relationship with control. In a broad sense, clinicians' sense of control, or lack thereof, has been represented in the research (Guttmann & Daniels, 2001; Valente, 2003). Researchers have found that mental health professionals often search for ways to regain their lost sense of control when they experience client suicide (Menninger, 1991; Rycroft, 2005; Valente, 1993, 2003). For instance, after experiencing client suicide some mental health professionals limit the work they do with suicidal clients while other mental health professionals choose to work exclusively with that high-risk population (Hendin et al., 2000). Like other clinicians, participants struggled to maintain or regain their sense of control. Participants described feeling uncertain and fearful about working with their first suicidal clients after having experienced client suicide. Unlike some mental health practitioners, though, school counsellors do not have the opportunity to structure their caseloads (Paisley & Borders, 1995; Ponec & Brock, 2000). Therefore, participants had to work through their fears in order to continue serving their school populations. While school counsellors typically cannot tailor their caseloads to fit with their interests, focus on an area of expertise, or limit certain populations (Barwick, 2000), they can regain their lost sense of control in a unique way.

Clinicians tend to view themselves as people who can inspire hope, positively influence clients in crisis, and in some cases even save lives (Berman et al., 2006; Gitlin, 1999; James, 2005). Part of the personal and professional impact of client suicide involved a shift in participants' self-perceptions. Client suicide shakes clinicians' core beliefs and leaves them questioning their professional and personal competence (Chemtob et al., 1989; Hendin, 2000, 2004; Richards, 2000; Valente, 2003). Participants, too, described a process of re-evaluating the adequacy of their professional skill-set and questioning their ability to handle the personal reality of client suicide. Prior to their experiences, participants believed they could successfully influence clients to choose life over death. The experience of client suicide confronted participants with their own personal and professional limitations. Afterward, they were left to reassemble the pieces of their shattered images.

For many clinicians, client suicide epitomizes the ultimate counselling failure (Grad & Michel, 2005; Menninger, 1991). Counselling is a collaborative process between clinician and client through which positive change is nurtured (Sink, 2005). When clients complete suicide, clinicians feel powerless in those relationships. While clinicians cannot change the decisions their clients make, school counsellors are in the unique position to influence how the school community processes their clients' suicides. Being active agents in their school communities' healing process reconnects school counsellors to their clients and to the collaborative process that was severed by the suicide.

School counsellors are instrumental in the enactment of their schools' postvention protocols (Maples et al., 2005). Their postvention protocol role significantly influenced how participants processed their experiences of client suicide. Five participants found that by organizing or being involved in the postvention protocol, they regained some sense of control. That control helped bolster their sense of professional competence, which enabled participants to continue practicing as counsellors. Further, participants believed that by actively working with their clients' bereaved family, friends, and teachers, they were able to honor their clients' memories.

Participating school counsellors could no longer support their clients but they could support those who were connected to their clients. Thus, school counsellors' involvement in their schools' postvention protocols gave them the chance to create some semblance of control out of chaos, which is not an opportunity afforded to most other mental health professionals. For some this process provided closure as they had the opportunity to contribute to community healing, while others felt obligated to help when they were in the midst of their own grief.

The responsibility for providing competent care increases for clinicians working with suicidal child and adolescent populations. Constant consideration is needed because most minor clients are not legally capable of making informed decisions regarding their treatment (Truscott & Crook, 2004). School counsellors assume greater levels of responsibility when working with their clients because they have an ethically and legally heightened duty of care. School counsellors not only grapple with their own sense of responsibility when a client commits suicide, they also have to sort through the uncertainty of the situation. Without a regulatory body that sets out standards of practice, school counsellors may wonder whether they fulfilled their responsibilities. Others who do have membership in an organization may worry that they will be held accountable for their clients' deaths. It was not surprising, therefore, that participants felt weighed down by their sense of responsibility and feared being blamed for their clients' decision to commit suicide.

Fear of being blamed in a case of client suicide is well-founded as many suicide survivors consider malpractice litigation when their loved ones die under the care of a mental health professional (Berman et al., 2006; Hendin et al., 2000, 2004). Successful litigation requires proof of negligent care (Remly & Sparkman, 1993); however, the responsibility for competent care increases when a child or adolescent is involved as children are not "autonomous individuals in the eyes of our society or their parents" (Truscott & Crook, 2004). In the past, school counsellors in the United States have not faced as many liability lawsuits as other mental health professionals because the courts recognized schools were not equipped to provide personal counselling (Maples et al, 2005). School counsellors were typically responsible for providing referrals and notifying parents when their children expressed suicidal ideation. The additional mandate of mental health counselling has raised new concerns for school counsellors. Those concerns were evident in this study as two participants were afraid they might be held legally responsible for their clients' suicides. Now that school counsellors have assumed a mental health role in the schools, fear of liability has surfaced.

The stigma of client suicide has manifested for clinicians as a fear of judgment (Berman et al., 2006; Gitlin, 1999; Hendin et al, 2000; James, 2005; Valente, 2003). For participants, fear of judgment played an even larger role than fear of litigation in their experiences of client suicide. These feelings of fear and vulnerability tend to keep clinicians from sharing their experiences with colleagues. Even the thought that clients could commit suicide can be enough to generate fear. Rycroft (2005) described how insidious this fear could be: "The suicide of a client represented my greatest professional fear. I wondered how other more experienced therapists dealt with this fear. They were silent, as I had remained silent in my fear, simply hoping it would never happen to me" (p. 86). Participants shared similar sentiments, admitting that they felt poorly prepared to deal with client suicide as the topic had never been addressed during their training or discussed with their colleagues. In essence, counsellors' fear of judgment served to further silence them, keeping them from sharing their experiences with colleagues, supervisors, and the larger community of grievers.

Given their role in the school community, school counsellors stand center stage in the crisis of student or client suicide (Adams, 2000; Stephanowski-Harding, 1990). School counsellors rely on the school community to trust in their ability to lead them through the crisis. Insinuation of blame by any member of that tight-knit community could tear apart that carefully constructed fabric of trust. Participants recognized their own vulnerability as they knew that students would be hesitant to seek their services and teachers would be wary of referring students to them if they were even thought to be culpable for their clients' suicides. One participant, for example, spoke about the considerable consequences his colleague faced when parents of a deceased client informally blamed him for their child's death. Fear of judgment and blame were never far from participants' thoughts as they knew that loss of trust and respect could result in personal and professional consequences.

Wearing the Mask

This theme underscored the complexity of integrating personal experiences with the professional context. Despite the recognition that suicide is an "occupational hazard" that mental health professionals will likely face (Chemtob et al., 1989, p. 419), there has been very little investigation into the personal impact experienced through this professional context (Menninger, 1991; Valente, 2003; Weiner, 2005). What is becoming clear as clinicians' personal experiences receive some attention is that "the differentiation of personal versus professional issues as it relates to a patient's suicide often becomes quite fuzzy" (Berman et al., 2006, p. 358). As the crisis of client suicide is being explored, researchers are discovering that the private and professional dimensions of client suicide are not mutually exclusive (Anderson, 2005; Berman et al., 2006; Rycroft, 2005; Valente, 2003).

Previous studies have attempted to quantify mental health professionals' experiences of client suicide (Chemtob et al., 1988; Chemtob et al, 1989; McAdams & Foster, 2000). Several have compared novice and seasoned clinicians' experiences and have found that novice clinicians experience higher levels of distress from client suicide than their more experienced counterparts (Hendin et al., 2000; McAdams & Foster, 2000). Participants in this study were at varying levels of experience when their clients committed suicide. In contrast to previous findings, participants who were novice counsellors at the time of their clients' suicides did not stand out as experiencing greater levels of distress than more experienced participants.

The level of distress for participants was mediated by several factors. Four participants who expressed high levels of distress believed they could have facilitated positive outcomes for their clients but were not listened to by people who were in positions of authority. In one situation the authority was the client's parents, in the other three situations the ultimate authority was the treating psychiatrist or social service agency. Therefore, participants' levels of distress increased when they felt like they were in powerless positions while in possession of important, but discounted, information regarding their clients' levels of suicidality.

Participants' distress levels related strongly to the nature of their counselling relationships. School counsellors interact with students in multiple contexts as they sometimes teach classes as well as coach, mentor, supervise, chaperone and counsel the students in their schools (Barwick, 2000; Tyson, 2000). School counsellors also have the opportunity to engage in longer-term counselling relationships with these children and adolescents as students attend a school anywhere from three to twelve years. Further, in the school system counselling relationships do not end with clients' deaths. Given the role school counsellors assume in the aftermath of client suicide, participants continued to work with the family, friends, peers, and teachers of their deceased clients. In other disciplines, treating mental health professionals may attend their clients' funerals but typically that is the extent of their involvement with their clients' family and friends (McAdams & Foster, 2002; Menninger, 1991; Valente, 2003; Walshe-Burke, 2006). The continued involvement participants had with the community of grievers after their clients' suicides seemed to intensify their connection to the deceased clients. Consequently, the more connected participants felt to their clients, the more distress they experienced when their clients committed suicide.

Alternatively, participants who felt disconnected from their clients experienced high levels of distress because they believed they missed the opportunity to intervene in their clients' suicide plans. Participants who worked with their clients for shorter periods of time wondered whether they could have positively influenced their clients if they had more time to work together. Schools are ideal settings in which to engage in longer-term counselling because counsellors have constant access to their clients but expanding mandates limit the time counsellors can dedicate to personal counselling. Also, access does not mean interest. One participant tried to engage a referred client in the counselling process but that client refused. Thus, the nature of the counselling relationship counsellors had with their clients played an important role as participants who had limited contact with their clients were left wondering if there was more they could have done.

Lack of resources impacted school counsellors' ability to process their experiences. In many work contexts mental health professionals practice in settings with colleagues, team members, and supervisors (Hendin et al., 2000). This practice model provides the opportunity for a psychological autopsy, supervisory consultation, or debriefing with team members after a client-completed suicide (McAdams & Foster, 2002; Richards, 2000). Participating school counsellors reported they rarely had the opportunity for such post-suicide processing. While psychological autopsies are common practice in the medical field (Gitlin, 1999), they are relatively uncommon in the school system. Psychological autopsies are performed to help counsellors work through some of the "doubts about her or his professional competence, and self-questioning about what she or he might have missed as a clinician that now feels like a lethal mistake" (James, 2005, p. 14). Moreover, they are used as an opportunity for the institution to review policies and procedures so that any learning that comes out of the autopsy can be applied to future situations. Reports indicate that as long as the treating clinician does not experience the autopsy as a public shaming, it can be helpful for the healing process (Gitlin, 1999). Unfortunately, this practice does not routinely occur in the school system because the resources have not been made available for school counsellors to create this atmosphere of learning and processing.

Mental health professionals regard supervisory support as an important component in their ability to process their experiences of client suicide (McAdams & Foster, 2002). Most school counsellors do not receive that supervisory support as they tend to practice without direct supervision. School administrators generally serve as school counsellors' supervisors of record; however, most administrators do not have a counselling background (Ponec & Brock, 2000). In some schools, counsellors work with colleagues who could provide peer consultation. However, the issue of confidentiality becomes a complicating factor. Typically clinicians conceal clients' identifying information during consultation. In the case of client suicide in a school, counsellors would not be able to conceal their clients' identities when consulting because their colleagues would be aware of the student suicide. Therefore, despite the benefit supervisory and peer support provides, most school counsellors do not have access to those resources.

Many school districts have established crisis teams comprised of school counsellors from different schools in the district who respond to student suicides. These teams provide students, staff, and sometimes school counsellors the opportunity to debrief immediately after the student suicide (King, 2001). The effectiveness of crisis response teams has been met with mixed reviews (Valente, 2003). One criticism of crisis response teams is that team member training is inconsistent and insufficient. In this study, for instance, four participants were members of their district teams but only two participants had been trained in crisis response.

Mental health professionals who surround themselves with supportive people, whether professional or non-professional, seem to experience less distress resulting in more manageable grief experiences (Gitlin, 1999; McAdams & Foster, 2002; Walsh-Burke, 2006). Similar findings were present in this study as participants reported that the support of non-professionals, friends and family, helped them process their experiences. The use and accessibility of personal support systems becomes critical for bereaved clinicians as most do not access professional services to help them process their own experiences (McAdams & Foster, 2002). This reticence to seek personal counselling has been addressed by some researchers. One explanation is that clinicians hold themselves to an elevated standard in which seeking professional support may imply poor personal and professional competency (Everall & Paulson, 2004). An alternate explanation is that clinicians are trained to tend to the needs of others, not their own (O'Halloran & Linton, 2000).

In this study, only two school counsellors accessed personal counselling services. Both counsellors who worked with professionals to process their loss experiences reported the experience to be both professionally helpful and personally healing. The professional counsellors who provided their services were trained in the areas of crisis response and trauma. They were able to alleviate participants' professional fears as well as support them through their personal process.

Five participants who did not receive professional support provided a variety of reasons for not accessing services. These reasons included: difficulty in accessing services from remote locations; not considering personal counselling as an option; having strong personal support systems; needing to focus on others rather than on themselves. Even though only two school counsellors accessed professional services, all of the participants acknowledged the importance of having professional support available for school counsellors who have experienced client suicide.

Personal and professional boundaries may blur for counsellors working in the school system. As they work within the school community, school counsellors have intimate knowledge of children and adolescents' peer relationships, academic achievement, school experiences, interests, and extra-curricular activities (Barwick, 2000; Heller, 2000; Sofronoff, 2005). Participants talked about their unique work context and how it contributed to the personal impact they felt from their clients' suicides. Participants believed they had an opportunity to act as positive influences in these young people's lives and tried to use that advantage to protect the youth. The investment counsellors make in their clients' well-being may be more pronounced for clinicians who work with child and adolescent populations than for clinicians whose primary clientele are adults (Berman et al, 2006; Stephanowski-Harding, 1990). Clinicians in the field of suicidology are of the opinion that the experience of losing a child to suicide is qualitatively different than losing an adult (Corr, Nabe, & Corr, 2006; Fielding, 2003; Freeman, 2005). Although participants did not have a frame of reference through which to compare the experiences of child versus adult suicide, they did acknowledge the significant care-giving responsibilities that they took on because their clients were children.

Clinicians who have experienced client suicide encounter both personal and professional isolation (Gitlin, 1999; Hendin, 2000; Morrissette, 2000). Many school counsellors who practice in smaller communities often work alone, have expansive role definitions, maintain long-term connections to students, develop dual relationships with students and staff, and experience limited access to community resources (Jewell, 2005). These limitations extend to the aftercare of counsellors who have experienced client suicide. Morrissette (2000) reported that when a student suicide occurs, "rural counselors were the least likely among school professionals to receive help in resolving such issues" (p. 198). Not only do rural school counsellors lack access to resources like their urban colleagues in the wake of client suicide, they also have the challenge of geographic isolation.

Consistent with existing research literature, rural school counselling participants talked about the impact of their clients' suicides on the community, their broad counselling role definitions, and the desperate need for resource support on a systemic level. As members of small communities, participants were dually affected as community members and as treating clinicians. Unfortunately, with few resources available, rural school counselling participants shouldered the brunt of the postvention responsibility. None of the rural participants received professional support. These rural practitioners were left to function independently, received little peer support, no supervisory consultation, and consequently had to work through their experiences of client suicide on their own.

For the sake of professional stability, some denial or suppression of emotion is common for clinicians in the aftermath of client suicide (Chemtob et al., 1988; Gitlin, 1999; Hendin et al, 2000, 2004; Maltsberger, 1992; McAdams & Foster, 2002). In the wake of a client suicide, clinicians continue to have active professional careers laden with responsibilities that require personal needs to often be set aside (Weiner, 2005). Consequently, mental health professionals become the rarely recognized, silent survivors of client suicide (Berman et al., 2006). In keeping with these research findings, participants suppressed their emotional experiences so they did not become paralyzed by their own overwhelming emotions as they attended to the needs of more recognized grievers. This practice of denial and suppression is further complicated for school counsellors by the roles they assume in the aftermath of their clients' suicides (Maples et al., 2005). Participants perceived that they were expected to spring into action after their clients' deaths as they had active roles in their schools postvention protocols. Participants believed that if they took time off to grieve, there would likely be no one prepared to lead the postvention protocol. School counsellors' sense of duty to tend to the needs of affected families and the school community overrode their own self-care needs.

The responsibility to care for the community of grievers would not usually befall clinicians in community or hospital agency settings as their responsibility would be to the deceased client not to the remaining family and friends. If a suicide was to occur in these other settings, a psychological autopsy would likely be conducted with team members (Anderson, 2005; Gitlin, 1999; McAdams & Foster, 2002; Parrish & Tunkle, 2005). The affected clinician would typically have the opportunity to debrief and team members would work to support the individual clinician to process the experience (McAdams & Foster, 2002). This does not happen in the school system because the aftermath of the suicide is when school counsellors need to take on leadership positions. Participants reported having no time to withdraw, reflect, or process their own experiences because they were most needed during the time normally set aside to grieve.

Though several of the participating school counsellors believed suppression of their emotions was necessary in the wake of their clients' suicides, that suppression created complicated grief responses for some. Complicated grief can have significant, lasting implications as the normal grief processes and tasks go unmet (Knieper, 1999; Stroebe et al, 2001; Walsh-Burke, 2006; Worden, 2002). Participating school counsellors intended to inhibit their grief response so they could perform their day-to-day counselling responsibilities. However, what could have taken the path of normal grief transformed into delayed or disenfranchised grief (Stroebe & Shut, 2001; Worden, 2002). This transformation has previously been documented in teachers whose students suddenly died (Rowling, 1994). Rowling (1994) found that teachers' disenfranchised grief responses were created by the human connection they had with their students, their need to be in control and to assume leadership positions, and from the duty of care they were required to provide. The factors that contributed to teachers' disenfranchised grief were all present for the participants in this study; like the teachers Rowling studied, these factors inhibited participants' ability to openly express their grief.

Rowling (1994) noted that teachers' experiences of disenfranchised grief were rooted in not being recognized by others as grievers, not recognizing their own grief responses, and the grieving rules set out formally or informally by the school. Similarly, participants' disenfranchised grief resulted from not being among those who were able to grieve because they had important care-taking roles to fill. Disenfranchised grief was further fueled by participants' reluctance to share their grief responses with others. This reluctance came out of a duty to protect and maintain their clients' confidentiality and out of the stigma attached to suicide. The right to confidentiality does not end with a client's death, self-inflicted or otherwise. Therefore, it was very difficult for participants to reach out for support when they had the responsibility of maintaining confidentiality looming overhead. Further, some mental health professionals are legally counselled to remain silent as statements made to colleagues could be used against them in court proceedings (Weiner, 2005). Maintaining confidentiality, though critical in the counselling profession, contributed to participants not fully sharing their experience with others.

Stigmatization also played a significant role in keeping participants' experiences private. Socially, suicide is dealt with differently than death caused by accident or from illness (Jordan, 2001). This was illustrated by one participant who talked about the delicate dance of collectively remembering the client's life in a school assembly without glorifying his death. Participants discussed the differences in school protocol, suggesting that memorials created in honor of deceased students are usually reserved for those who died by accident or illness. Student suicides are acknowledged but not formally recognized. Shame further served to cement clinicians' bond of silence. According to Rowling (1994), helplessness contributes to the shame experience. Mental health professionals have the expectation of being helpful. When a client commits suicide, clinicians question their competency, wonder what would have happened if they had been able to support their clients in a different way, and experience guilt or remorse over how some of the counselling may have unfolded (Berman et al., 2006). These factors contribute to the stigmatization of suicide and the silence that it leaves behind.

Like many clinicians in other mental heath disciplines, five participants attempted to work through their own grief issues without any formal counselling (McAdams & Foster, 2002). All participants eventually found ways to access support from colleagues, friends, or family. However, even after accessing support, six participants said they had not fully disclosed their experiences to others because of issues related to confidentiality, stigma, or shame. Three participants reported never really discussing their experiences until participating in this study. While supervisory support has been identified as one of the most helpful resources for counsellors dealing with client suicide, it is the least accessible option (McAdams & Foster, 2002). None of the participants had the opportunity to debrief their experiences with supervisors.

Interpreting the Dance

The importance of finding ways to work through the personal loss and feelings associated with participants' experiences of client suicide was addressed in this theme. Client suicide has been termed an occupational hazard for clinicians (Chemtob et al., 1988, p. 419), which has a personal impact: "suicide of a patient in therapy is the most difficult bereavement crisis that therapists may encounter" (Berman et al., 2006, p. 358). Participants clearly stated that client suicide is a very personally painful experience that must be appropriately processed. Therefore, attention must be paid to how clinicians experience client suicide and to what clinicians need in order to experience a healthy response.

Participants' strong therapeutic relationships with their clients intensified their experiences of client suicide. The uniqueness of school counsellors' relationships with clients has been previously explored (Borders, 2002; Lockhart & Keys, 1998; Sink 2005). School counsellors have the opportunity to develop intense therapeutic relationships with clients as they are on the frontlines interacting with these children and adolescents daily (Borders, 2002; King et al., 1999). McAdams and Foster (2002) inferred from their findings that the intensity of counsellors' reactions positively correlates with the strength and nature of the therapeutic relationship. As school counsellors have the opportunity to develop strong therapeutic bonds with their clients and have the unique holistic perspective of their clients engaged in their familial, peer, and school realms, participants' personal reactions to their clients' suicides were understandably intense.

The personal impact of client suicide on clinicians has not been well recognized (McAdams & Foster, 2000; Richards, 2000; Valente, 1994, 2003). Traditionally the term *suicide survivors* was limited to the family and friends of the deceased. Mental health professionals who have experienced client suicide are just beginning to receive recognition as legitimate survivors (Grad et al., 2005; Knieper, 1999; Weiner, 2005; Rycroft, 2005). Preliminary findings have suggested that the nature of bereaved family and friends' emotional responses are similar to the distress clinicians' experience in the wake of client suicide. Mental health professionals have identified "feelings of loss, helplessness, anger, guilt, and self-incrimination, and for an estimated one third of these therapists, severe distress" (Berman et al., 2006, p. 271) which are in line with the feelings expressed by the family of friends of the deceased. Participants' emotional experiences also corresponded with other mental health professionals' experiences, which mirror bereaved family and friends' emotional states. Therefore, treating mental health professionals across disciplines, family, and friends of individuals who commit suicide all tend to experience similar emotional processes.

With the recognition of clinicians as suicide survivors comes the need for clinicians to develop a personal construction of themselves as grievers. Participants oscillated between validating their own feelings as legitimate and emphasizing the needs of more traditionally recognized survivors. Describing her experience of client suicide, Rycroft (2005) spoke to this uncertainty: "How could I ever compare my feelings to those who had lost a vibrant, talented and loving sister and daughter? What right did I have to grieve when I had let them all down so badly?"(p.85). Like Rycroft, participants had difficulty acknowledging that they belonged among the community of grievers.

Funerals tend to be a place where people have cathartic grief experiences (Anderson, 2005; Bateman, 1999; Walshe-Burke, 2006). Catharsis occurs because funerals are a socially sanctioned place where people gather to mourn, support one another, and connect with their spirituality. Three participants reflected on the significance of their funeral experiences, describing the funeral as the place they allowed themselves to finally express the emotions they had been bottling up. However, not all participants experienced a positive emotional release. Participants who did not have positive recollections of their clients' funerals said they were essentially work venues where they comforted the close friends and family of the deceased or they felt intense anger toward the parents of their deceased clients and/or the mental health professionals who had rebuffed their warnings. One participant did not know about her client's suicide in time to attend. In the research literature, mixed responses have also been reported for people attending funerals for individuals who committed suicide. Funerals for those who died by suicide can have stigma attached which may undermine the cathartic benefit of social or public grieving (Jordan, 2001, Lester, 1998). Other researchers have found that funerals, even for those who committed suicide, provide an opportunity for counsellors to experience some closure (McAdams & Foster, 2002).

Given the different ways participants addressed their experiences of client suicide, their grief responses and recovery times varied. This experience is typical of counsellors who have lost clients to suicide as so many factors contribute to how those experiences are processed (Walshe-Burke, 2006). Clinicians' tendency by training is to help others; therefore, participants' focus post suicide was on attending to the needs of their school community rather than to their own needs. James (2005) noted the heightened sense of responsibility clinicians experience stating: "respondents felt more responsible for the suicide of patients than for those of people in their personal lives" (p. 14). Counselling is a care-taking profession. Consequently, clinicians often assume some responsibility for their clients' well-being. When clients committed suicide, participants transferred their care-taking sense of responsibility from their clients to those left to grieve.

Staying in the Game

The final theme mapped the journey participants embarked on to reach a place where they were comfortable continuing to work. All participants identified working with their child and adolescent clients as their primary motivator to stay in the profession. While they suffered the loss of one or more clients, they also reveled in the successes many of their other clients experienced. School counsellors are in the position of working with the whole spectrum of client issues. One client may want to discuss post-secondary school options and the next client may express suicidal ideation. As one participant commented, that balance was enough to keep her from being overwhelmed by her client load. The diversity of their clientele helped participants find ways to retain their sense of competency while working with what they described as a challenging yet rewarding population.

Part of the healing process for participants involved recognizing that their experiences would not fade away to distant memory. Participants worked to release the pain but kept the lessons learned. Two participants spoke about ways they remembered their deceased clients on the anniversary of their deaths. One participant described how he has come to terms with the presence of his clients in his dreams. Two participants were involved in writing curriculum dealing specifically with suicidal clients. Participants created different ways to remain connected to their experiences without feeling paralyzed by their raw emotions.

In the same breath that participants acknowledged the importance of self-care, they also talked about their continued struggle to find a healthy balance. All participants had self-care strategies they credited with keeping them able to perform their counselling responsibilities. Like many other mental health care professionals, participating school counsellors acknowledged the difficulty of finding time for self-care.

Consistent with the literature and despite the reported benefits, participants did not identify using artistic expression to process their experiences. One of the barriers to creative expression noted in the literature is: "seasoned participants lamented that they are so exhausted at the end of the day or work week that they simply can't find the energy or time to meet their own needs for creative expression" (Walshe-Burke, 2006, p. 97). While participants may not have used creative expression to help them process their losses, they used other strategies to achieve that release. Participants spoke about the importance of physical release through exercise and maintaining balanced lifestyles including proper nutrition. One participant went for regular massages. Four participants acknowledged spirituality as a commonly accessed resource during their difficult times. It is now recognized that "spirituality and religion are very important influences in people's lives, particularly in coping with death and loss" (Walshe-Burke, 2006, p. 69). Having a spiritual resource to provide comfort and support helped participants remain hopeful about their counselling contribution and have faith in their ability to help children and adolescents. While professionals' own self-care needs are the first to be neglected (Walshe-Burke, 2006), participants found ways to maintain their own strength.

Personal counselling has been reported as the best resource for coping with and recovering from the experience of client suicide (McAdams & Foster, 2002). That noted, very few mental health professionals including the school counselling participants accessed personal counselling after experiencing client suicide. Only two participants accessed personal counselling services. Even though five participants went without formal counselling, they credited their support systems—friends, family, pets, colleagues—with providing them some outlet for expressing their experiences of client suicide.

Summary

In keeping with the research literature, participants described the complicated relationship they had with control, specifically the lack of control they experienced. Contributing to participants' feeling of lack of control was limited access to resources and a heightened sense of responsibility due to clients' ages. The issue of legitimizing school counsellors as suicide survivors was also addressed as much of the emphasis in the research literature has been on what clinicians can do to address and anticipate the needs of bereaved students and staff, not on how to process their own experiences. In this study, participants consistently spent less time in their interviews focusing on the themes involving self-care, which were Interpreting the Dance and Staying in the Game. The primary emphasis was placed on the client and work dominated themes of Taming the Control Beast and Wearing the Mask. Perhaps the interviews reflected the struggle participants alluded to regarding work versus self-care. Participants seemed more apt to care for others than to tend to their own needs.

Implications for School Counsellors

The role of the school counsellor has changed in recent years (Ballard & Murgatroyd, 1999; Sink, 2005). With mental health concerns among school-aged children increasing and continued budget cutbacks to mental health, school counsellors are becoming increasingly responsible for servicing the mental health needs of the entire student body (Atkinson & Hornby, 2000; Lockhart & Keys, 1998). Further, school counsellors are in a position to address the mental health needs of students (Tyson, 2000) because they have considerable contact with these youth during their formative years (Heller, 2000; Sofronoff, 2005). Given that "it has been estimated that up to 50% of completed suicides were in treatment at the time of their death" (Berman et al., 2006, p. 348), school counsellors will likely be involved in a student suicide, if not a client suicide. Thus, preparation for such likelihood has become increasingly important.

Training

Training is the foundation on which preparation is formed. Most graduates of counselling programs, though, receive little training in suicide prevention, intervention, and no training in postvention (Dexter-Mazza & Freeman, 2003; Westefeld, Range, Rogers, Maples, Bromley, & Alcorn, 2000). Similarly, school counsellors have noted that suicide is the most stressful client issue they encounter, yet they receive no preparation in their training programs for dealing with the aftermath of suicide (Jewell, 2005). In a study Kendrick and Chandler (1994) conducted, they found that 93% of the school counsellors sampled had worked with students expressing suicidal ideation. A smaller percentage of school counsellors will experience the aftermath of their clients' decisions to move from ideation to action.

Contrary to other research findings, all participants received some training through workshops or courses on suicide prevention and intervention (Dexter-Mazza & Freeman, 2003). Two participants received limited postvention protocol on-the-job training as they were members of their districts' crisis response teams. In keeping with the research literature, no participant had ever taken a course or workshop that addressed the probability that counsellors would experience client suicide. Further, counsellors' needs and emotional experiences after a suicide were never formally or informally addressed. Therefore, participants were not sure whether their experiences of client suicide were normal, whether they were supposed to have such an emotional reaction, or whether as one participant stated they were "allowed to grieve". Clearly training to this point has been too limited and consequently not helpful in dealing with client suicide (Dexter-Mazza & Freeman, 2003; McAdams & Foster, 2002; Stefanowski-Harding, 1990). Changes need to be implemented so that counsellors receive training in suicide prevention, intervention and postvention processes.

This lack of preparation is not limited to school counselling training programs. Berman et al. (2006) reported: "although the study of suicide is considered a relatively important element of clinical graduate training, formal training of any kind in suicidology occurred in only 35% of clinical psychology doctoral programs sampled" (p. 7). Across the mental health profession, training centers neglect to address the probability of client suicide and the appropriate course of action to take when clients commit suicide. Unfortunately, the reality of suicide is not sufficiently dealt with in training facilities so mental health professionals must navigate the experience of client suicide on their own (Dexter-Mazza et al., 2003; Stephanowski-Harding, 1990; Valente, 1994, 2003).

In addition to the special circumstance of working with child and adolescent clients, any time confidentiality of a client is breached an ethical dilemma exists (Truscott & Crook, 2004). In most counselling disciplines, concrete guidance, usually in the form of ethics codes, is used to work through the ethical decision-making process. Psychologists refer to the *Canadian Code of Ethics for Psychologists*, counsellors certified by the Canadian Counselling Association (CCA) follow the *CCA Code of Ethics*, but school counsellors do not have a national text to consult when working with suicidal clients. Not only are school counsellors adrift without a guiding document, they also have few if any colleagues with whom to consult. Participating school counsellors revealed their common experience of feeling afraid when they had to navigate this process alone.

National Training/Practice Standards

National standards for training and practice that guide service delivery need to be implemented so there is consistency between school districts within and across provinces. At the present time, each school district has considerable power in determining the role, training, and function of counsellors in their schools. Consequently, with no national mandate, significant differences in school counsellors' training and practice exist. For instance, due to the counsellor shortage in Newfoundland and Labrador, teachers have been assigned counselling positions (Cooper, 2004). The Manitoba School Counselling Association reported: "school counsellors are essentially clinicians, working with almost no safety net . . . with little or no supervision . . ." and are asking to be "adequately trained and supported" (Robertson & Boxer-Meyrowitz, p. 17). In British Columbia litigation against untrained counsellors motivated many districts to require that new school counselling appointees hold a Masters degree (Easton, 2004). Some provincial school counselling associations have drafted their own ethics codes, while others follow their provincial teaching codes. The few national constants seem to be that budgetary cutbacks to mental health services have resulted in school counsellors assuming more of a mental health role, large counsellor-student ratios (1:500, 1:693; 1:1200), and access to fewer community resources (Butler, 2004; Cooper, 2004; Donovan, 2004; Easton, 2004; Robertson & Boxer-Meyrowitz, 2004).

Crisis Intervention/Debriefing

National standards for training and practice need to extend to suicide prevention, intervention, and postvention. Counsellors face enough uncertainty without having to figure out these protocols on an individual basis (Westefeld et al., 2000). Times of crisis are not times when counsellors should learn about postvention protocol. The purpose of a crisis intervention plan is to have carefully constructed procedures in place so that a crisis is managed skillfully by a number of staff members who have clearly defined roles (King, 2001). Dissemination of information, debriefing, support and counselling are all parts of the crisis intervention plan. Counsellors need to be part of a team that works with the school community to facilitate healing—they should not shoulder that responsibility on their own (King, 1999).

Further, in the case of client suicide, structures need to be put in place to address the needs of affected counsellors. As part of the postvention protocol, some school counsellors participated in formal debriefing with crisis team members. One participant described the debriefing process as a daily event in the days immediately following a student suicide. However, debriefing has met with mixed reviews in the research literature (Valente, 2003) and participants noted that inconsistent and insufficient training impedes the effectiveness of debriefing. One participant said he did not find his debriefing experience to be helpful because he felt judged by one of the facilitators for selecting a particular self-care strategy. Another participant felt supported in her initial debriefing experience and would have appreciated the experience to be ongoing and more in-depth. What was clearly stated by all participants was the importance of having support in implementing the postvention protocol but still being involved so that they could regain their compromised sense of competence. In order for crisis teams to be effective, districts need to invest in member training.

To meet the needs of counsellors who have lost clients to suicide, school districts can ensure that the following provisions are put in place: (a) a supportive and nonblaming staff atmosphere that ensures that a range of feelings can be expressed and understood (b) the availability of a neutral consultant or consultation group, and (c) training to supplement prior training and experience with suicidal people (Berman et al., 2006, p. 360). If these structures are proactively engaged, counsellors will have easy access to information, resources, support, and training.

Professional Support

Professional counselling has been identified as the most supportive resource for clinicians processing their experiences of client suicide (McAdams & Foster, 2002). However, clinicians rarely receive counselling services to help them deal with their own issues (Everall & Paulson, 2004). Five participants who did not receive professional counselling explained their reasons for finding other ways to work through their experiences. Two participants knew about the Employee Assistance Program (EAP) personal counselling support available to them but felt awkward about reaching out to colleagues because they thought they should be able to work through it themselves. One participant said he did not reach out for support but would have accepted help had it been offered. He talked about counselling himself through his healing process and spoke about how difficult it was engage in self-therapy. Another participant was concerned there might be professional repercussions for seeking personal services. The final participant believed she worked through her grief by talking with colleagues, friends, and family. Even though participants constructed their own support systems, only one participant was encouraged to access personal counselling services. Not only does encouragement for school counsellors to seek support in dealing with the aftermath of client suicide need to be improved but support measures need to be put in place for counsellors so that the accessing of services is normalized and readily available.

Supervisory Support

Supervisory support is critical for mental health professionals working through their experiences of client suicide (McAdams & Foster, 2002). Next to professional counselling, supervisory support has been cited as the most helpful resource for professional community counsellors, psychologists, and psychiatrists working through their loss experiences (Hendin et al., 2000; McAdams & Foster, 2000; Richards, 2000). Supervision, though, is not always available. School counsellors, for instance, often practice in isolation without direct supervision (Lambie, 2004). Supervision from experienced clinicians provides the safety net of shared responsibility, guidance, and opportunity for personal debriefing (McAdams & Foster, 2002). Participants found that lack of supervision contributed to their self-doubt, vulnerability, and fear. Clinical supervision would provide school counsellors the opportunity for professional development, limit liability in the circumstance of client suicide, and enable a supporting role in the postvention protocol. As counsellors have assumed a mental health role in schools, supervision needs to be an integral component of any comprehensive school counselling program (McMahon & Patton, 2001).

Peer Support

As supervisory support is difficult to access and very few mental heath professionals turn to personal counselling to help them process their experiences, support often comes in the form of consultation with colleagues or friend and family support (Gitlin, 1999). Friends and family may offer comfort but they lack the professional skill-set required to truly consult on a case, debrief personal process, and understand the complexity of the counselling context. Therefore, peer or colleague involvement can provide support for clinicians both personally and professionally. For some professionals in private practice or school settings peer support is more difficult to access because clinicians often practice independently (McMahon & Patton, 2001; Valente, 1993; Worden, 2002). Professional connections between counsellors, then, need to be fostered at the district level so that school counsellors, even in rural areas, have the opportunity to contact peers for professional consultation and support.

Burnout

Experiencing client suicide clearly has a personal and professional impact. The impact of working in stressful contexts can affect clinicians' mental and physical well-being (Arvay & Uhlemann, 1996). Mental health professionals' well-being and susceptibility to burnout is mediated by a number of factors. Feeling overloaded, role ambiguity, lack of supervisory support, and inexperience or a younger age are all variables that contribute to burnout (Maslach et al., 2001). Factors such as working with difficult clients, carrying a large caseload, and experiencing limited control over the work context also play a role in burnout (Arvay & Uhlemann, 1996). School counsellors are subject to all of these factors.

Generally novice clinicians seem to experience more distress when confronted with significant stress or trauma (Arvay & Uhlemann, 1996; Chebtob et al., 1998). Though the findings in this study did not differentiate counsellors' distress levels by years of experience, participants did report increased confidence in their clinical judgment and greater access to resources with additional work experience. Further, all participants in this study were trained professional counsellors, which is not the case for all individuals employed as school counsellors. Due to recruitment difficulty or limited budgets, some districts employ untrained counsellors, usually teachers, to fill school counselling positions. The impact of no or limited training on stress and burnout can only be hypothesized as no studies to my knowledge have been conducted on this population. However, if novice mental health professionals experience greater levels of distress and burnout, a natural extrapolation would be that untrained counsellors experience even higher levels of burnout. Counsellor training and continued professional development, then, need to be high priorities for school districts as additional experience and training seem to equate with more confident mentally and physically well counsellors.

Fewer outside resources have meant that counsellors are working with increasingly complicated mental heath issues for a larger population of students. The added responsibility of personal counselling has meant that school counsellors are engaging in longer-term counselling with clients and at the same time are having to expand their scope of practice. Not only are school counsellors responsible for students' academic guidance, they are now responsible for students' mental health as well. This addition of mental health work to guidance coupled with a change in role definition has contributed to larger caseloads.

Moreover, working in schools under the direction of administrators who have a limited understanding of the demands placed on counsellors puts counsellors in somewhat powerless positions. School counsellors have a limited ability to control and influence their work environments. Participants described how their roles have expanded over time and talked about their willingness to accommodate those increased demands because they were willing to do anything they could to ensure services were provided for their clients. School counsellors work in contexts that put them at increased risk for fatigue; therefore, protective measure need to be in place in order to prevent school counsellors from burning out.

Self-Care

Self-care needs to be modeled, taught, and supported as a professional resource. Self-care is not a luxury or an indulgence. By integrating self-care into training programs, it can become part of a healthy professional identity for counsellors who are working in demanding, stressful, high-needs environments. While clinicians know that "developing strategies for self-care is an essential component of ongoing professional development that can sustain counselors and help them to avoid compassion fatigue, or burn-out" (Walshe-Burke, 2006, p. 96), they struggle to meet their self-care needs because they have been trained to care for others to the detriment of their own health (O'Halloran & Linton, 2000). A high level of stress can compromise counsellors' personal health and their professional abilities (Arvay & Uhlemann, 1996). Yet, self-care for clinicians working in the area of trauma has not been heavily researched (Arvay, 2001). Clinicians need to be encouraged to care for themselves so they have the strength to care for others. In many ways, self-care is the preventative practice that enables mental health professionals to continue working in their demanding field of choice.

Considerations for Future Research

The impetus for this study was the desire to create a forum for school counsellors to share their experiences of client suicide. The findings suggest that while school counsellors share similarities with other types of mental health professionals, school counselling is a unique discipline. It could be important to further study school counsellors' experiences of client suicide in order to better understand what similarities they share with other helping professionals and also how their roles differ from their mental health counterparts. Research into both their counselling contexts and the counselling relationships they develop with clients could be avenues for further exploration.

School counsellors often lead the postvention protocol in their schools. Participants described feeling overwhelmed and unprepared. Important information could be gained from studying how school counsellors feel about their postvention roles and how they could be supported in this necessary process. The benefits of this research may include greater understanding of the roles school counsellors adopt in crisis situations, the impact of those roles on school communities and the counsellors themselves, and areas for support and training that have not been previously addressed.

Although there was diversity among the sample in this study—approximately equal male to female participant ratios, representation across the country, variable levels of experience, adequate mix of rural and urban experiences—it would be interesting to conduct research with a larger sample of school counsellors. A larger sample might reveal elements of the experience of client suicide that this study did not uncover. Contextual factors such as location of practice, years of experience, and type of training might become interesting variables to explore with a larger sample of participants. While this study had depth, a greater breath might make a valuable contribution to the research literature.

It would also be interesting to discuss with counsellors their reasons for choosing not to participate in research studies. At least nine school counsellors who were identified as meeting the criteria for participation chose not to be included in this study. After an initial discussion with two potential participants, it was determined that they did not feel ready to talk about their experiences of client suicide. The other seven potential participants were identified through personal contacts and participants, but did not contact me for more information. Therefore, an investigation of school counsellors hesitancy to participate in such a study might produce valuable information that was missed in this study because participants self-selected.

Six potential participants expressed interest in participating in this study but they did not meet participation requirements. Three individuals were working as school counsellors when their clients committed suicide but they did not have the counselling training required for participation in this study. Two potential participants were trained counsellors but had students rather than clients commit suicide. One potential participant was a university school counsellor who had a client commit suicide. It may be interesting to explore untrained counsellors' experiences of client suicide and to expand a study to include counsellors' experiences of student suicide. Many counsellors have been involved in postvention protocols for students in their schools who were not counselling clients. Further, many counsellors are involved with their districts' crisis teams and respond to schools in the aftermath student suicide. These could be very powerful experiences to explore as well.

The level of participant involvement in this study was quite high as counsellors participated in multiple interviews, read and revised transcripts, maintained communication with the researcher, read chapter four and were asked to respond to that chapter in written form. Research requiring less time and commitment from participants may be helpful for recruiting a greater sample size and more generic information. Participants shared detailed information about their experiences of client suicide in this study; a different format targeting basic information about school counsellors' experiences might elicit more participant interest.

One area that warrants further study is the circumstance of mental health professionals experiencing multiple suicides. Very limited research has been done with clinicians who have lost multiple clients (James, 2005). One participant who had experienced multiple client suicides found that she dealt with the subsequent suicides with more clarity. She knew what to expect in some ways both emotionally and professionally so she could allocate time to deal with her loss and knew how to access the resources she needed. Another participant who had two clients commit suicide found that the second experience was compounded by the first. He found himself processing both experiences even though he thought he had previously dealt with his first client suicide. These different experiences by two participants raised some important questions that were beyond the scope of this study. Therefore, an investigation into the experiences of clinicians who have lost multiple clients to suicide would satisfy some of the questions raised during the course of this study such as: What is the impact of multiple suicides on clinicians' sense of competency? How do clinicians continue to work with suicidal clients after experiencing multiple client suicides? What if any changes to clinical practice are made after such experiences? What impact on clinicians' well-being (i.e. slow burn or burnout) occurs after multiple client suicides?

Another area that warrants study is clinicians' primary versus secondary traumatic stress experiences. Secondary traumatic stress has been studied in certain clinician populations (Arvay, 2001); however, at least one participant in this study seemed to experience primary traumatic stress. It would be interesting to explore clinicians' primary as well as secondary traumatic stress responses in the wake of client suicide. Such research could focus on how each form of traumatic stress affects clinicians, how the two trauma responses differ, or on the impact of experiencing both primary and secondary traumatic stress.

Research on the differences between counsellors who stay in the profession and those who switch schools, careers, or quit the profession could be an important contribution. All participants in this study remained in their chosen fields. However, the career counselling one participant engaged in after her experience raised the question: how do school counsellors decide whether to continue on or leave the profession? Participants were able to explain their reasons for staying but the perspectives of counsellors who left the profession were absent from this study.

Connected to the decision of continuing in or leaving the counselling profession is the issue of counsellor well-being. School counsellors' well-being has not been addressed in the research literature (Morrissette, 2000). Research on the impact of school counsellors' role ambiguity, expanding mandates, and newly acquired mental health role on counsellors' well-being could be important to determine. Role ambiguity, increased workload, and work-related stress contribute to burnout (Maslach et al., 2001) and therefore this research could have implications for school districts, training institutes, and ongoing professional development for school counsellors.

Participants in this study addressed to some extent the importance of self-care as it related to career longevity. However, further investigation into the self-care strategies and lifestyle characteristics of clinicians who continue to work in the field after experiencing client suicide could provide useful information for mental health professionals. Some elements of self-care addressed by participants make sense intuitively but have not been addressed in the literature. For instance, it is generally accepted that connection to spirituality can be a supportive resource for bereaved family and friends (Berman, 2006). However, clinicians' attendance to their spirituality has not been addressed in the research literature. Further information on self-care strategies of long-term counsellors could be useful for districts considering the implementation of preventative strategies. Taking a proactive stance could diminish counsellors' stress leaves, sick time, and career changes. It would also be useful information for novice counsellors just beginning their careers as they could take proactive measures to maintain their mental and physical well-being.

Conclusion

Client suicide has a profound personal and professional impact on mental health professionals. As the experiences of school counsellors who have lost clients to suicide had not been addressed in the literature, the purpose of this study was to give voice to those perspectives. The experiences these study participants shared do not represent the experience of client suicide for all school counsellors but they do offer an opening for discussion, thought, introspection, reflection, and future research. Now that these initial seven experiences have been shared, it is my hope that research in this field continues to uncover the untapped resource of school counsellors' experiences.

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